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**“Because we are kaffirs with short hair”**

**A study of embedded trauma and repetition in a  
community-based organisation**

by

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A minor dissertation submitted in partial fulfilment of the requirements for  
the award of the degree of the Master of Arts in Clinical Psychology  
at the University of Cape Town

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## **Abstract**

This research looks at the experience of being a psychologist-in-training providing psychological services to a staff support group in a community-based organisation located in a township. The staff support group consisted of health workers drawn from the local community. At the time I entered the staff support group, the organisation was in a financial crisis and facing an imminent closure. This seemed to have re-evoked earlier traumatic experiences for the community health workers and resulted in a multi-layered response from them, which manifested itself in the discussions in the staff support group.

The multi-layered response prompted my desire to undertake this research. The layers that I explored were the impact of the imminent closure on the individuals (the community health workers), the organisation and the local community. To do this I wanted to apply psychodynamic theory and decided to use self-psychology and intersubjective theories to understand what was being experienced within the organisation. I conducted seven interviews with community health workers, management and permanent facilitator of the staff support group. In addition I reviewed the organisation's records and analysed the staff support group session notes. The results of this research confirmed my initial observations and showed that there was indeed a complex multi-layered response from community health workers, and this raised questions on the role of psychologists working with organisations such as these. Finally, some recommendations are made about the role of community psychologists and ways to work with community-based organisations that are vulnerable to the trauma inherent in the community setting.

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**Declaration**

I, Nontsikelelo M. Ndumela (UCT student no: NDMNON001) do hereby declare that this work has not been previously submitted in whole, or part, for any award of any degree. It is my own work. Each significant contribution to, and quotation cited in, this dissertation which comes from the work, or works, of other people, has been duly referenced and attributed.

Signed by candidate

University of Cape Town

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# CHAPTER ONE

## INTRODUCTION

### 1.1 Background to the research

This research is based on a case study of a community-based organisation (CBO) in Khayelitsha, situated about 35 km outside Cape Town, where I was placed for my community project in 2002 to co-facilitate a staff support group. The placement formed part of the first year of my clinical psychology master's training at the University of Cape Town (UCT), Child Guidance Clinic (CGC). In this research I have referred to the organisation as 'the CBO' in order to preserve anonymity. My experiences as a psychologist-in-training at the CBO, co-facilitating the staff support group prompted me to undertake this research. This group had been established by the CGC in 1996, to provide training to the community health workers<sup>1</sup> at the CBO. This was my first experience of the CBO and also my first experience of working in a community setting.

In the year of my work with the staff support group, the CBO had run out of funding, and closure seemed imminent. Its future had always been insecure – it depended solely on donors for its financial stability – and it had often faced threats of closure in the past. During 2002 however, closure seemed certain and the community health workers were handed letters of retrenchment halfway through the year. (At the last session of the year with the group, the community health workers informed us that the management had decided to keep employing them until June 2003. The CBO currently operates as a Non-Profit Organisation (NPO).) This research focuses on my experience with the group during 2002, on the interviews conducted with some members of the CBO in 2003, and the organisation records that I reviewed.

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<sup>1</sup> Meaning 'health workers drawn from the community'.

## 1.2 The community-based organisation and its context

The CBO was established to make mental health accessible to the local community. In 2002 it was the only organisation of its kind providing mental health services in Khayelitsha. It was a small project, managed at that time by a local tertiary institution, although in many ways it operated as a CBO/NGO. It was staffed by six community health workers who were employed as case managers, and a psychologist who worked part-time as project co-ordinator. Most of the community health workers originally came from the Eastern Cape, and reflected the composition of the community they worked and lived in.

Khayelitsha is one of the biggest black townships<sup>2</sup> in the Western Cape. It was created in the early 1980s (SALDRU, 2003) by the apartheid government, as part of a strategy to control the black population in the Western Cape. The government decided that if it could not remove blacks from the Western Cape altogether, then it would move them to a place where it would be easy to police and control them (Lawyers Committee for Human Rights, 1988; Unterhalter, 1987). Over a period of more than a decade, thousands of Africans were forcibly removed from other informal settlements namely KTC and Crossroads to Khayelitsha. During this time the Western Cape experienced heightened violence and people were displaced and killed whilst resisting forced removals (Lawyers Committee for Human Rights, 1988).

According to the census of 2003, Khayelitsha houses about 330 000 people, living predominantly in squatter housing. The 2003 census estimated that 53% of its employable population (age between 15 and 69 years) was unemployed, while 59% of its total population had a level of

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<sup>2</sup> In South Africa, the word 'township' refers to urban areas previously designated for black people (Africans, Coloureds, and Indians). These areas are situated far from central business districts and are characterised by poor infrastructure and a lack of resources such as water in each home, electricity and water-borne sanitation. (Under the new government things are slowly improving.)

education below Grade 11. Only 15% of the total Khayelitsha population has a Grade 12 or higher level of education. Nearly half of the households (42%) in Khayelitsha are headed by women with children. Recent crime statistics indicated that Khayelitsha is one of the most violent communities in Cape Town.

### **1.3 Rationale for the research**

#### **1.3.1 Trauma and repetition within the CBO**

Each staff support group session that we conducted in 2002 was characterised by language and words that were filled with feelings of pain, anger, betrayal and distrust of management. The imminent closure seemed to have evoked powerful emotions, and unresolved issues between community health workers and management emerged. The community health workers felt strongly that they had been treated unfairly. It seemed that they had not expected the CBO to close, despite the fact the organisational documents and session notes indicate that they were aware that 2002 was going to be the end of a financial phase and possibly of the CBO. I was therefore interested to find out why the community health workers were reacting in this way and feeling so hurt. This formed the basis and rationale of this research.

The community health workers' response to the crisis reflected the subtle and complex interfacing of various levels of trauma. The crisis highlighted the inter-relationship between personal experience, politics, and organisational dynamics, which were present when the organisation was established and which had never been adequately addressed. For instance, the group was preoccupied not only with fighting to keep their jobs but also with fighting the 'whites' (management) who were perceived as not treating them fairly. There was a clear racial undertone in their reaction, and it echoed the South African political past of discrimination and segregation. The relationships that had developed since the inception of the organisation mainly

between community health workers and management, disintegrated during this time, and there was a strong sense of “us and them”.

### **1.3.2 The role of psychologists working in a community-based organisation**

Although the CGC had initially been requested by the CBO project co-ordinator to provide training to their community health workers, it became clear to me that we would only have contact with the community health workers and were accountable only to them. As facilitators we did not have any contact with management at the project site, or with the local tertiary institution. Based on my previous working experience as a management consultant<sup>3</sup>, I knew that this type of engagement (implementing an intervention in an organisation) required that management or leadership own the process and take the lead, but in this case management was not involved. This seemed likely to raise many contradictions and conflicts because our role was meant to be neutral, and contact with management was crucial. Our interaction with the organisation was thus fundamentally split. That is, our efforts in the staff support group was not linked to the functioning of the organisation as a whole. I was left with the feeling that, as facilitators, we were colluding with the splitting in the organisation. From my OD consulting experience I felt that we could do more, and that merely providing a containing space and our empathic understanding was not enough. Based on my experience this concern formed the second part of my rationale for this research.

### **1.3.3 The research question**

Bearing in mind the arguments I have outlined above, this research raised two questions;

1. How did the imminent closure at the CBO re-enact broader socio-political crisis and history?

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<sup>3</sup> I worked as an organisational development (OD) consultant for 8 years prior to my clinical psychology training

2. When working with community based organisations such as the CBO, how do community psychologists engage and work within this context. That is, can they remain involved at a micro level or the nature of such crisis requires them to bear in mind the broader context of the organisation.

#### **1.4 Structure of the thesis**

Chapter Two gives a broad overview of community psychology and its role, including key debates in South Africa. It highlights the context within which organisations function and the issues faced by organisations working in a community setting in South Africa. This context and issues, raised are considered in terms of the implications for community psychologists.

Chapter Three provides a discussion of the application of the psychodynamic theory on community psychology, organisations and groups.

Chapter Four outlines the methodology of this research.

Chapter Five provides details of the case study and of the data collected from the staff support group sessions, the interviews and the CBO's own records.

Chapter Six provides a discussion of the results. It then draws broad conclusions and puts forward recommendations and suggests issues to be considered in future research and in the role of community psychologists.

# **CHAPTER TWO**

## **COMMUNITY PSYCHOLOGY IN THE CBO CONTEXT**

### **2.1 Introduction**

In this chapter I begin by discussing community psychology in order to provide a framework for this research. This section will include the definition of community psychology and the fundamental principles and challenges facing community psychology in a post-apartheid society. Thereafter, I will discuss the history and challenges faced by non-governmental organisations (NGOs) and community-based organisations (CBOs) in South Africa. Finally, I will explore lessons from development theory that might be useful to community psychology.

### **2.2 Community psychology**

The field of community psychology is fairly new and originated in the USA in the 1960s. During that time there was a recognition of the failure of mainstream psychology in addressing mental health problems because of its individualistic approach, which located the illness within the individual rather than in society (Pretorius-Heuchert & Ahmed 2001; Long, 2002; Gibson, 2002a). It became clear that a new model was needed, one which would acknowledge the role of socio-political and economic factors in the development of mental illness.

#### **2.2.1 What is community psychology?**

Seedat, Duncan and Lazarus (2001) argue that community psychology is defined by its tenets and the radical ideals that it upholds, and that these are reflected in the theory, methods and application of the discipline. Community psychology regards the following areas as central to its philosophy and theoretical assumptions (Seedat et al., 2001):

1. Improving accessibility to health care, particularly for those sectors of society that have been historically disenfranchised.
2. Changing the understanding and interpretation of the production and creation of psycho-social problems.
3. Creating a milieu in which social and environmental factors are perceived as critical in the analysis of psychological problems.
4. Revolutionising the application of psychology and the delivery of mental health care to previously disadvantaged members of society.

According to Seedat et al. (2001) community psychology is a branch of psychology distinguished from mainstream psychology. Its emphasis indicates a key ideological assumption which highlights “the psyche of the collective” and also elicits “an academic activist agenda seeking to reform, redirect or revolutionise the theory, method and practice of psychology in the interest of disadvantaged groups.” (ibid., p.3). Its underlying philosophy is to increase the understanding of the ways in which individuals interact with their environment, through relevant theory, research and practices (ibid.; Pretorius-Heuchert & Ahmed, 2001). It seeks to reform or even revolutionise the theory, method, and practice of psychology in the interest of the disadvantaged groups (Seedat et al., 2001).

Community psychology is heterogeneous, consisting of different perspectives and models. This makes it difficult to arrive at a definition that can capture all its different aspects and approaches, these being the mental health, ecological and organisational perspectives (Pretorius-Heuchert & Ahmed, 2001). Their common feature is an emphasis on the development of theories, methods and praxis that “locates individuals, social settings, and communities in [a] sociocultural context” (ibid., p.19). There is a common recognition that “the interaction between individuals and their

environment is important in terms of alleviating [psycho-social] problems” (ibid.). This emphasis distinguishes community psychology from mainstream psychology.

2.2.2 Community psychology and the role of the community psychologist

The emphasis of community psychology in South Africa and elsewhere is on striving for the upliftment of poor people through an improvement in their socio-political and economic conditions (Maw, 1996, 2002; Long, 1999; Seedat et al., 2001). To do this, community psychology has specific objectives when working with individuals, groups, organisations and communities. It aims to play a specific role, as illustrated in Figure 2.1<sup>4</sup>.

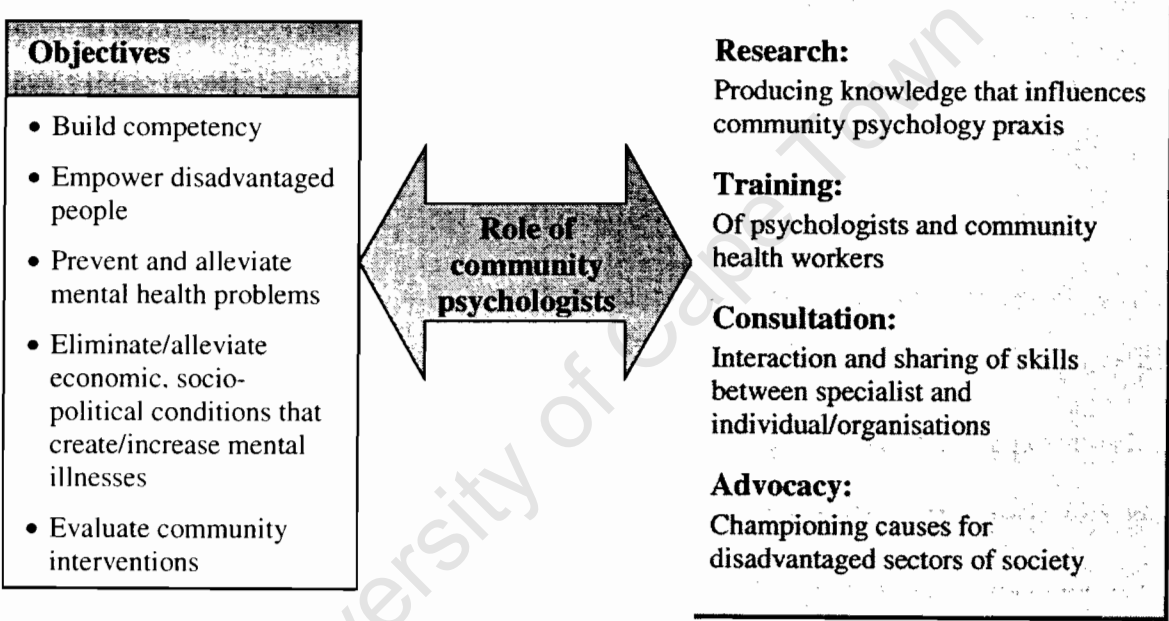


Figure 2.1

The role of community psychologists thus involves research, training, individual or group or organisation consultation, and advocacy (Pretorius-Heuchert & Ahmed, 2001; Gibson, 2002a).

<sup>4</sup> Based on Pretorius-Heuchert & Ahmed, 2001; Maw 1996:2002



Maw (2002) argues that the role of community psychologists also involves confronting and addressing power imbalances that are created by race, class, gender, language, culture and knowledge, particularly in South Africa “where difference has been institutionalised through apartheid”(p.57). Drawing on her experience of a consultation relationship with a community health worker and drawing on Foucault (1984) Maw (2002) argues that power difference is not necessarily negative as long as it is acknowledged and addressed:

By acknowledging and naming the power differentials, frequently through the constructs of race, class, language, gender and/or culture, I felt freer to include within the consultation work, elements of training, teaching, supervision, advocacy, and psychotherapeutic intervention (p. 60).

In South Africa it is difficult to ignore the effects of apartheid, especially the way it has destroyed the relationships between different races and led to lack of trust amongst people (Gibson 2002b). Community psychologists in South Africa therefore require additional skills to equip themselves to “deal with the aftermath of apartheid” (ibid. p.10).

### **2.2.3 Community psychology models**

There are two main models of community psychology cited by authors such as Long (1999), Gibson (2002a) and Ahmed & Pretorius-Heuchert (2001). The first is the *mental health* model and second the *social action* model. In addition, some South African authors have explored other models that could assist in addressing local issues (Ahmed & Pretorius-Heuchert, 2001; Hamber, Masilela & Terre Blanche, 2001).

The mental health model focuses on the prevention and reduction of incidents of mental illness and is positioned within the traditional mental health care model. It has been criticised for its perception of mental illness, seeing disease as something “that can be treated or prevented” (Ahmed & Pretorius-Heuchert, 2001, p.70). It has also been criticised for ignoring structural

inequalities and other issues, such as poverty, that create mental health problems (Long, 1999; Ahmed & Pretorius-Heuchert, 2001). In this model mental illness is seen to be located in the individual rather than having been constructed by society and its dysfunction. Primary health care programmes in South Africa are based on the mental health model, so their approach remains 'service based and individualistic' (Long 1999, p.11). In this model the role of community psychologists is thus limited to being professional advisers to individuals, organisations and communities (Ahmed & Pretorius-Heuchert, 2001).

The social action model is regarded as a radical option and emphasises the need for changes in the social and political structures that create imbalances and inaccessibility to mental health (Ahmed & Pretorius-Heuchert, 2001). Long (1999), citing Butchart and Seedat (1990), argues that the social action model suggests empowerment as a vehicle for addressing social and political imbalances. This empowerment process includes the recognition the power of a community and its resources.

The social action model has been popular locally and overseas and is similar to the 'giving away' psychology argument (Orford, 1992 cited in Long, 1999). However, the social action model has been criticised for oversimplifying the power relations between those who have power and those who do not, and "paradoxically disempowering through its failure to recognise the power of resistance" (ibid. p.11). Seedat et al. (2001) argue that the focus of the social action model is limited because it ignores the need to transform the underlying economic structure, which maintains and contributes to the existing socio-political inequalities. Thus the empowerment approach may be limited in that it benefits only a few without addressing deeper socio-economic inequalities.

For both models 'community' is identified as an area of intervention, and defined as a recipient of mental health services. It is important to note that I have thus far been using the term 'community' generically; later in this chapter I shall discuss some of the debates around this term. The mental health model defines community as "a geographical catchment area" (Seedat et al., 2001, p.6). The social action model defines community as a "political collective unit" (ibid.). However, Seedat et al. (2001), citing Butchart & Seedat (1990) and Seedat & Nell (1990), argue that the way that 'community' is perceived in both models portrays it as a natural phenomenon rather than recognising the social and political factors inherent in the way in which a community evolves. This view suggests that the concept of community needs to be challenged, rather than treated as a 'given'.

### **2.3 Community psychology in South Africa**

Community psychology emerged strongly in South Africa in the 1980s (Seedat et al., 2001; Gibson, 2002a). Several authors have argued that the origins of community psychology, particularly in South Africa and Latin America, are strongly associated with socio-political struggle and defiance (Maw, 1996; Seedat et al., 2001; Gibson, 2002a). These authors propose that community psychology in general emerged as a liberal approach in reaction to injustices and systems that were fundamentally discriminatory. Locally, it held a 'promise' to liberate South African psychology from the psychology of the 'first world'<sup>5</sup> (Seedat et al., 2001; Maw, 1996; Gibson, 2002a).

This research will not explore the development of community psychology in South Africa. There are many authors who have done this; for example see Gibson (2002a), Pretorius-Heuchert & Ahmed (2001), Hamber et al., (2001), Maw (1996) and Long (1999). It is nevertheless important

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<sup>5</sup> Euro-American psychology

to highlight some key aspects which show how community psychology has evolved in South Africa, which are relevant to this research.

In post-apartheid South Africa, community psychology has been marked by many debates and challenges regarding its 'liberatory promise' (Gibson, 2002a). Some authors such as Hamber et al. (2001) have expressed concern that "the tradition of locating psychological phenomena within political and economic realities, started by South African community psychologists, is in danger of being abandoned in post-apartheid South Africa because direct political oppression is no longer such a dominant feature of our society" (p.55). These writers have also expressed concern that community psychology's well-meant interventions "run the risk of patronisation and recolonisation" (ibid., p.57), particularly because community psychology always targets township people for its interventions. These debates form part of an attempt within community psychology to find a relevant and appropriate model that will address the complexities facing South African community psychologists in post-apartheid society.

### **2.3.1 Debates surrounding community psychology in South Africa**

The tenets of community psychology in South Africa centre on community participation, empowerment, "democratisation" of knowledge production, and "community based interventions" (Swartz & Gibson, 2001, p.41). However, despite its achievements, community psychology has yet to achieve "community participation, engagement, power, and control" (Seedat et al., 2001, p.5). Community psychology is criticised by local writers for the poor representation of authors outside academic institutions. Some authors have referred to this as the "distortion of knowledge production" (ibid.) as community psychology lacks representation from communities. This also indicates that there is virtually no community participation in producing knowledge and shaping community psychology praxis.

Community empowerment approaches have been found to be problematic, allowing only a few to benefit from community interventions. Empowerment approaches have also been criticised for not challenging the underlying economic structures that impact on community empowerment and participation. Using a Marxist framework, Hamber et al., (2001) argue that, in a society characterised by the contradictions that are part of any capitalist society, community psychology interventions could be “seen as propping up the system” (p.57). They warn that community psychologists should be “constantly aware that short-term gains are sometimes achieved at the cost of the long-term perpetuation of a system of exploitation” (p.57). Therefore, although community psychology has the potential to assist in uplifting living standards and accessibility to mental health, it has an equal potential to maintain the status quo.

A second debate in community psychology questions the definition of ‘community’ – the term most used in the field of community psychology (Long, 1999; Gibson, 2002a). Some writers see these critiques as particularly relevant in the South African context where this term is used only to refer to the black community (Maw, 1996). Long (1999) argues that “the concept of community is particularly fraught given the historical effects of apartheid and the Group Areas Act” (p.9).

Seedat et al. (2001) argue that a tendency to use the term ‘community’ without sensitivity can hide the underlying complexities and meanings of terms such as ‘race’ and ‘ethnicity’ in South Africa (p.6). They suggest that the use of ‘community’ lends a false sense of credibility to the notion that a particular community actually exists when in fact it may not. Following on from this, Long (1999) and Gibson (2002a) argue that there could be some form of idealisation of the ‘power of communities’ while the political meaning and history of this term is overlooked. The

concept of community thus cannot be used in South Africa without taking into consideration its political and social meaning.

A third debate centres around the use of community health workers in extending mental health delivery. According to Swartz & Gibson (2001), the phrase 'community health worker' (CHW) has various meanings and definitions but "in the current context it is used to refer to people who are not formally trained in the health field but who, with a relatively brief training, are put to work, generally in their own communities" (p.42). The use of CHWs in South Africa is an initiative to extend the few mental health resources available, particularly in black communities. This framework provides a unique opportunity for the CHW to work closely with her/his community and in an environment that she/he is familiar with (Swartz & Gibson, 2001), and where she/he can develop 'culturally appropriate interventions' (p.42). However, this framework is based on the assumption that a CHW is representative of and understands the needs of her/his community, which may not be the case. In their chapter in Seedat et al. (2001), Swartz and Gibson (2001) provide a detailed discussion on the issues surrounding the use of CHWs and highlight the difficulties of this concept. They also draw from other writers such as Binedell (1993), Berman, Gwatkin & Burger (1987), and Walt (1990). It is important to note that although the use of this concept has been helpful in extending mental health services, there is a danger of romanticising the idea of 'community' (ibid.). I would also argue that this concept could be seen as patronising and it also implies that disadvantaged people are responsible for their history and conditions. So far the role of CHW has been assigned to black people from disadvantaged background, it is therefore important ensure this role not perceived belonging only to this group.

### **2.3.2 Community psychology and the search for an appropriate framework**

The failure of the traditional mental health model, which is informed by traditional approaches, has compelled professionals and researchers in the field to consider alternative approaches in addressing mental health needs in South Africa (Pillay and Lockhart, 2001). It has been argued that a community psychology approach, which continues to draw on traditional psychoanalytical principles, retains an individualistic focus (Hamber et al., 2001). There is a recognition within community psychology that the knowledge and understanding of the relationship between the individual and the social context needs to be extended. For example, using a Marxist framework, Hamber et al. (2001) provide a different way of understanding mental health in a capitalist system, which is currently dominating the world economy. In their chapter in Seedat et al. (2001), they describe patterns of relationships in capitalist systems and explain how these create structural conditions that are traumatic to society. According to their argument, economic structure is characterised by a class struggle between the middle and lower classes. In this struggle community psychologists occupy a middle class position, which impacts on the way they understand and view mental health issues. Psychological problems are thus linked to the economic structure and reality and cannot be understood outside of this framework. They suggest that “the very least we can do is to develop a critical awareness of our own social and economic role, and the way in which this limits our ability to influence society’s mental health” (p.64). Although the scope of this research cannot accommodate the complex debate and criticisms of the Marxist argument in the literature, it is important to note that this argument position an individual as a product of her/his material conditions and excludes personal experience (Gibson, 2002a).

The challenge for community psychology is to find an approach that attempts to recognise the way in which individuals internalise their experiences while acknowledging the role of social and

political impact in this (Gibson, 2002). Writers such as Long (1999) have drawn on the influence of the contemporary psychoanalytic theories such as relational theory, which argues that 'self' is a social construct, by using organisations as platform for their studies. This shows new thinking about how the way in which an individual interacts with his or her environment. Gibson (2002) argues that "on a practical level, organisations may provide the opportunity to witness, explore and address the relationship between social and the individual more fully" (p.24).

There is however limited knowledge of organisational functioning within community psychology, and psychodynamic framework, which is discussed in the following chapter seems well placed to assist in this area. Boyd & Angelique (2002) note that articles that have been written about organisational issues within community psychology (from 1977 to 2000) excluded organisational constructs and theories. In addition, they also found that community psychologists are trained to study individual phenomena and lack skills in examining macro issues. The study of organisational issues and systems could assist community psychologists in closing this gap (Boyd & Angelique, 2002). For instance, it may be useful for community psychologists to understand organisational structure, context, and the relationship between different systems within an organisation whilst attending to psychological issues. In this research I will use both psychodynamic framework and systems theory to explore organisation, groups and individual behaviour of the community health workers at this CBO. The systems theory is an organisation theory that will guide this research. Like community psychology, systems theory focuses on the interface between the individual and its environment.

Systems theory stresses the importance of studying and understanding individuals, groups and organisations in their context (Bennett 1994; Brown, 1995). It seeks to explore both micro and macro issues and the way in which these impact individuals, groups, and organisations. Systems



theory suggests that people are influenced by their environment, as a result, researchers have begun to investigate the influence of environmental factors on organisation, group, and individual behaviour (Boyd & Angelique, 2002). Bennett (1994) states that systems theory acknowledges and pursues an analysis of the ways in which individuals interact with each other within an organisation and broader context.

According to systems theory, an organisation is understood to be a cluster of interrelated components that interact with one another and/or with their environment. These include organisational culture, structure, management processes, and technology (Bennett, 1994; Boyd & Angelique, 2002). This theory regards an organisation as an active entity that interacts with both the internal and external environment. The use of systems theory in community psychology and study of organisations can therefore help to understand the complexities and subsystems that define relationships between people and organisations. In this research it is employed to help me identify issues within the organisation and outside that contributed to the re-enactment of trauma.

### **2.3.3 Conclusion**

Although community psychology is still evolving and is limited in certain aspects, it has managed to distinguish itself from mainstream psychology through its emphasis on socio-political transformation, particularly regarding the needs of the previously oppressed and disenfranchised (Seedat et al., 2001; Maw, 1996; Gibson, 2002a). The literature reviewed indicates that community psychology is still in the process of identifying its role in post-apartheid society. The distortions and difficulties inherent in the current mental health models have been highlighted, such as insufficient empowerment, collaboration, and lack of participation on the part of the communities. There is a need within community psychology to establish a voice that is truly representative and empowering to communities.

There is however an ongoing search within community psychology to develop an appropriate framework to address the complexities faced by community psychologists in South Africa. Community psychologists are now grappling and considering how to think about individuals both at micro level and the way in which they interact within a broader social and political context. In addition, there is also a recognition that the study of organisations can further the understanding of individuals.

## **2.4 Community-based organisations in South Africa**

This research focuses on a CBO, and an account of these organisations in the literature is given below. It is important to note that, although this research is based on a CBO, this section also deals with NGOs because the distinction between the two is very blurred (The following section discusses this overlap). Because the literature on CBOs and NGOs involved with mental health delivery is limited, information is also drawn from other sources such as political studies. Pillay and Lockhart (2001) discuss NGOs as one of the mental health models and their arguments are included in this section.

### **2.4.1 Defining CBOs and NGOs**

The 'voluntary sector' in South Africa refers to non-profit organisations, which consist of CBOs and NGOs. NGOs are defined as organisations that "provide professional services to community groups of a particular constituency" and CBOs "bring constituency to the grassroots level and often is the recipients of services provided by NGOs" (Development Update, 1999, p.3). However, in most situations in South Africa the distinction between these organisations is not clear and CBOs often provide the same services as NGOs. In addition, an organisation can act as a CBO in one setting and as a NGO in another (Kihato & Rapoo, 1999; Development Update,

1999). In a study that Kihato and Rapoo (1999) conducted on civil society organisations in South Africa, which included NGOs and CBOs, they found that the way the organisations describe themselves (as NGOs or as CBOs) “reflected the identity they would like to project to their beneficiaries, funders [and] government” (p.11) rather than the way they see themselves. In addition, the results of their study showed that organisations frequently chose more than one category through which to label themselves. Therefore, it may not be useful to rely on these particular terms in describing or defining the category of an organisation.

In addressing some of the difficulties surrounding the definition of NGOs and CBOs, Kihato and Rapoo (1999) suggest that in South Africa these terms refer to “part of a discourse denoting a set of fundamental values regarded as important throughout the non-profit sector (p.13). These common values include playing an active role in improving service accessibility for communities which have hitherto been marginalised because of their social and/or economic status. These values are reflected in the history and challenges facing CBOs and NGOs in South Africa, which will be discussed in the next section. The use the terms NGOs and CBOs in this research therefore embodies these common values of organisations that operate in the non-profit sector in South Africa rather than to a specific organisational structure or entity.

#### **2.4.2 Key challenges for NGOs and CBOs in South Africa**

In considering the context within which CBOs and NGOs function in South Africa, it is important to take into account the nature of their political history, both pre- and post-1994. This history has had a significant effect on the challenges they face, particularly in post-apartheid South Africa (Shubane, 1999a).

#### ***2.4.2.1 Background and context***

During the last part of the twentieth century there was a strong growth in voluntary activity in South Africa, particularly in organisations working in social development and in health (Edwards & Hulme, 1992), and the struggle against apartheid undoubtedly galvanised activity in the sector. In the 1980s, the “common enemy became a unifying link for these organisations, even though they had different political agendas which ranged from dismantling the structure of apartheid to fundamentally restructuring the social and economic environment” (Shubane, 1999a, p.7). During this time there was an increase in the number of NGOs in South Africa, which were established to play a central role in the struggle against apartheid (Shubane, 1999a). For instance, some of these NGOs played a crucial role in making mental health services accessible to oppressed and disadvantaged communities (Pillay & Lockhart, 2001).

Prior to 1994, NGOs and CBOs had a relatively easy period financially, and funding was readily available. Donors did not have stringent policies, and organisations were selected for funding on the grounds that they were fighting against apartheid and contributing to the struggle for a non-racial country (ibid.). This also facilitated the establishment of many NGOs whether or not they met a clear need (ibid.). Major donors such as the European Union (EU) and the United States’ Agency for International Development (USAID) channelled a lot of money into South Africa. Shubane (1999a) argues that “funds of this magnitude made available by donors were bound also to create a huge dependency within NGOs” (p.27). As a result, the view that without substantial donor funding not much can be achieved by NGOs in South Africa continues to be widespread.

#### ***2.4.2.2 Challenges in a post-apartheid society***

Although South Africa witnessed another boom in the number of NGOs and CBOs between 1990 and 1994, these organisations were about to experience serious challenges to their existence,

particularly after the first democratic election of 1994. Local writers have described the period between 1990 and 1994 as a period of transition and reconciliation in South Africa (Kihato & Rapoo, 1999). Most of these organisations established during this period aimed to “address the social deprivation created by apartheid” particularly in health care and related areas (ibid. p.26). Three main challenges affected NGOs and CBOs in South Africa after the first democratic election of 1994:

Firstly, they found themselves losing many of their staff to government and to the private sector who had held leadership positions in NGOs and CBOs up to that point (Booth, Ebrahim & Morin, 2001). As a result a leadership gap was opened in the sector and some of the organisations, especially the smaller ones, collapsed.

Secondly, the NGO sector saw a decrease in funding as donors preferred to deal directly with the new government. The few donors who continued to fund NGOs and CBOs directly began to change their funding policies and also demanded that NGOs and CBOs be accountable and submit detailed financial reports. NGOs found it difficult to adapt, partly because they lacked the skills needed to do this, and partly because prior to 1994 there had been little monitoring of the use of funds and no real culture of accountability. NGOs and CBOs had simply spent the funds in whatever way they saw fit. The effect of the dependency that had been created by foreign donors in the 1980s began to show. NGOs and CBOs were struggling to survive and some found themselves in serious predicaments, and without the skills to raise and manage funds (Shubane, 1999b).

Thirdly, while the role of NGOs and CBOs during the apartheid era had been very clear (fighting the system while alleviating the consequences of poverty and disenfranchisement), after 1994

many NGOs struggled to adapt their vision and goals to the new political situation. Their role came under scrutiny as the projects they were undertaking began to be questioned. The issue of whether these projects were really meeting the needs of local beneficiaries became pertinent, as NGOs and CBOs found themselves having to change their focus and objectives to meet those of their donors in order to get funding (Green & Matthias, 1997; Kihato & Rapoo, 1999; De Jong, 2003).

These issues indicate the vulnerability of NGOs and CBOs “to the external pressures on their overall direction [and the challenges they face] in staying true to some best features of [their] work and in holding to a radical, sustainable approach to development” (Harding, 1994, p.2). The mere existence of organisations working within communities challenges them not only to address the specific issues for which they were established but also to play an active role in social, economic, and political upliftment (Harding, 1994).

#### **2.4.3 The role of CBOs and NGOs in mental health delivery**

The work of NGOs in mental health services is based on concepts and objectives developed in a context driven by needs rather than theory. Historically their work has targeted specific geographical areas and responded to specific problems, such as violence and trauma, within communities (Pillay & Lockhart, 2001).

South Africa carries a legacy of insufficient and under-resourced mental health services. Local authors have highlighted the shortage of mental health professionals (Maw, 1996, Gibson, 2002a, Moultrie, 2004), saying that their numbers will never be adequate to meet the mental health needs of people from poor areas (Pillay & Lockhart, 2001). The problem is exacerbated by the failure of the traditional mental health care approach, “which has a history of passively waiting for

people who have the necessary insight and economic resources to seek consultations from mental health specialists” (p.88). This approach does not work in South Africa where there is legacy of inadequate service delivery to the poor (Maw, 1996) and high rates of poverty and its sequelae, so NGOs and CBOs become useful service providers in terms of meeting the mental health needs of those living in poor areas.

A good example of this is in the field of children’s mental health services. Research contributions from this sector are significant because they show that mental health services outside the metropolitan boundaries are under-resourced and limited or even non-existent in many areas, particularly at community level (Pillay & Lockhart, 2001; Gibson, 2002a). Pillay & Lockhart (2001) argue that the majority of the services available in the under-resourced areas are provided informally and based on the ‘band-aid approach’, which originated in 1980s. At the time the provision of the mental health services was a part of a reaction to the oppressive social and political policies of the apartheid regime. The need therefore, for carefully constructed, pro-actively oriented community services is evident (ibid.).

#### **2.4.4 Conclusion**

NGOs and CBOs have made significant contribution to the provision of mental health and related services, including initiating projects at community levels, where there had been few or no services (Pillay & Lockhart, 2001). There is a great need for structures such as these, particularly at community level, thus ensuring their sustainability and survival becomes crucial in South Africa.

## 2.5 Sustainable development

Thus far I have argued that community psychology's tenets, particularly in South Africa, are based on removing the structural inequalities that define the lives of poor people. The complexity of dealing with social, political, and economic structures as part of social change has been highlighted in this literature review. In addition, the shortcomings of community psychology around community participation and empowerment have been discussed. In other areas, such as sociology and related fields, social change is linked to a need for sustainable development. This is discussed below. These development perspectives could contribute to the definition of the role of the community psychologist in social change.

### 2.5.1 Background

The failure of the North<sup>7</sup> to sustain development in the South<sup>8</sup> has sparked many critiques and debates, encouraging inquiry into the causes of these impasses. 'Sustainable development' has become a buzz-phrase in the development sector and amongst those who work within community based organisations (L. Huna, interview, March 2003<sup>9</sup>). Debates are ongoing about what constitutes sustainability and who or what is to be sustained. In recent years there have been questions in the literature about the role of the North and its policies in the South. Many authors in development fields have argued that the approaches adopted by first world countries towards developing economies have been crippling rather than enabling (Green & Matthias, 1997; Taylor, 2002).

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<sup>7</sup> i.e. the 'first world' countries

<sup>8</sup> 'Third world' or developing and underdeveloped countries

<sup>9</sup> Development practitioner at Community Development Research Association (CDRA) in Cape Town. I have used her as one of the information sources on sustainable development in South Africa because I found that there were few black woman voices in this area. She was also familiar with the CBO that this research is based on.



There is a growing consensus and recognition that power relations need to shift between donors from the North and beneficiaries in the South. For example, in South Africa black people have been freed from oppressive apartheid policies but it may be argued that, until they are economically empowered, they will not be fully free (Huna, interview, June, 2004). The way in which relationship between North and South has been structured historically has reinforced a paradigm of dependency by the South on the North. This relationship is based on power and on access to resources, particularly financial (ibid.). The need to revisit this relationship is informed by a need to find a way in which power relations are not reinforced but are transformed, and to develop strategies which encourages 'sustainable thinking' and enables the South to function independently (Middleton & O'Keefe, 2001; Taylor, 2002). What this approach suggests is that it is not the role of the professionals who work with communities to do the thinking for those communities and make decisions on their behalf. Professionals must help communities to think through the issues that dominate their lives, and make their own decisions. In this way communities will allow sustainable development to become a part of their lives and social change (Huna, interview, June 2004).

### **2.5.2 Defining the concept of sustainable development**

The principles elucidated in the previous section inform the definition of sustainable development. 'Sustainable development' is generally defined, according to the World Commission on Environment and Development (WCED), as "... development that meets the needs of the present without compromising the ability of future generations to meet their own needs" (WCED 1987, p.8 in Mutubuki, 2003, p.59). This definition offers some guidelines for sustainable development and highlights the discourse and debates in the development sector. Although it recognises the need for empowerment, involvement and continuity in developing communities, the definition has failed to clarify the types of economic and social strategies that

are required to “maintain a path of sustainable development in the future” (Harding, 1994, p.8). The definition is clear however about the threat that social and political factors pose to sustainable development (Harding, 1994).

### **2.5.3 Paradigms of sustainable development**

Development practices are divided into ‘conventional’ and ‘alternative’ paradigms. Both of these include the development of individuals, community, organisations and society (CDRA Annual Report, 1997/98). However, the CDRA report states that the conventional paradigm remains dominant amongst development practitioners<sup>10</sup> (ibid.).

The philosophical and theoretical underpinnings of the conventional paradigm suggest that development is constructed. That is, the provision or donation of resources (for example funds, service delivery, skills and infrastructure) together with a changing of policies will empower people and enable them to live in a ‘developed’ way (CDRA Annual Report, 1997/98). This paradigm has been criticised for concentrating on “doing things *to* or *for* people rather than *with* people” (CDRA Annual Report, 1999, p.3). Critics of this approach assert that, although conventional development can lead to transference of skills, which may be of benefit, it more often leads to dependency and a disruption of existing viable paths of development.

Furthermore, critics of ‘conventional development’ argue that the ideas held consciously or unconsciously by practitioners as to what ‘developed’ means for the South is a replica of and reflects the praxis of the North (Middleton & O’Keefe, 2001; Taylor, 2002). Proponents of the alternative paradigm argue that “the wealth of the North has been historically and is presently

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<sup>10</sup> Anyone who works in development and is developing the capacity of other people (CDRA Annual Report, 1997/98).

based on the cheap resources and labour drawn from the South” (CDRA Annual Report 1997/98, p.1) and that “a change in the conditions of poverty in the South will require not only that the South changes and develops but that the economies and societies of the North themselves change and develop” (ibid.). They suggest that the North needs to change, and to change in a way that allows a different global system to occur: a global system that can acknowledge and respect the South’s own choice of a path of development.

The philosophical and theoretical underpinnings of the alternative development paradigm suggest that development is a natural process that already exists in any community or society (Taylor, 2002). For example, it is argued that during the apartheid years oppressed people survived and managed to sustain themselves, development was in fact happening. So, when development practitioners intervene, they intervene into a living system, which means that development will continue even after they leave; people will continue to find ways of surviving and sustaining themselves (Huna, interview, June 2004). Taylor (2002) argues that professionals working in this field need to realise that they “do not ‘bring’ or deliver development, but intervene into development processes that already exist” (p.8).

It is argued that, whether the intervention is targeted at an individual, an organisation, or a community, the process of development is the same and ongoing. This approach means that practitioners “intervene *into* the development processes of people themselves, be it individuals, groups, organisations or communities” (CDRA Annual Report, 1997/98, p.2). Therefore the term “people-centred development” which is coined by the alternative development paradigm becomes significant because it acknowledges that development is taking place, and encourages people to gain power and control over their lives, and make choices for their future (Taylor, 2002; Middleton & O’Keefe, 2001).

#### **2.5.4 Is it money that makes development sustainable?**

Sustainability, particularly for organisations, is often perceived by those in the development field as equivalent to ‘having enough money’, for without it, it is believed, development cannot take place. Local writers such as Thaw (2002) and Hugow (2002) argue that in most cases this assumption hinders development because people tend to think that they cannot do anything without money. These writers argue that money is not a major issue in development because development happens anyway (Hugow, 2002; Huna, interview, June 2004). Money is perceived as one type of resource amongst the many that are required for development. It is argued that people have their own resources simply as human beings; for instance, people who live in rural areas grow vegetables and find ways of using the land in order to sustain themselves, even though they have little money (Huna, interview, June 2004).

In this alternative paradigm, money is seen as creating problems in development and as potentially inhibiting creativity. People have an ability to drive change without money. Using one of the organisations with which she is currently working as an example, Huna argues that most organisations are dying without money, even though they started without it (interview, June 2004). For example, some organisations started with volunteers, but as soon as they started to employ people on a salaried basis, money became an issue and the problems began. Huna (2004) suggests that it is the perceptions about money and the power issues tied to it that need to change (Hugow, 2002, Huna, interview, June 2004). Thaw (2002) argues that there are other factors, particularly in organisations, that create ‘unsustainability’: factors such as lack of vision, strategy, ideas, well-being of staff, and staff participation.

Hugow (2002) argues that visionary leadership that propagates sustained positive change is crucial in achieving sustainable development. Leading a development organisation, whether it is

a CBO or an NGO, in a post-apartheid society makes certain demands on a leader (Hugow, 2002). These demands are driven by both internal factors (transformation to the new dispensation) and external ones (donors and increasing need for services). However, leading and managing a non-profit organisation is not well-conceived in the field, and theory to guide this is very limited (ibid.). Citing Anheier (2000), Hugow (2002) argues that there has been a tendency in the field to rely on theoretical models and principles borrowed from business. Therefore “not much has been written about the unique challenges that leaders and managers of voluntary non-profit organisations face” (ibid. p.3). This creates a gap in understanding the complexities faced by these leaders; complexities inherent in the nature of the organisations. Non-profit organisations are often very complex in their structures and tasks, and as a result require a mix of different leadership skills, including traditional management skills and relational leadership (Hugow, 2002).

#### **1.5.5 Conclusion**

Development is an ongoing process, which means that “the most fundamental challenge facing the development practitioner is to understand the development process into which she or he is intervening. That is, to know where the individual, the organisation or the community is located on its path of development” (CDRA, Annual report, 1997/8, p.14). This will not happen until there is shift in power dynamics and a change from the classical paradigm which suggested that development begins in the South only when the North enters the process.

#### **2.6 Summary**

The tenets and praxis of community psychology in South Africa were developed to defy and fight the political oppression of apartheid a system which was based on dehumanising and oppressing the majority of the South African population. Community psychology has played a significant

role in challenging traditional models and making psychology relevant to the South African context. However apartheid has left profound emotional scars and created political conflict between different races in South Africa. There is a need within community psychology to study the way this political experience has been internalised and how it has affected relationships between different races, as well as how this political experience is re-enacted in micro-systems such as groups and organisations.

Working developmentally entails thinking about our position on the power continuum. Further, it requires an acknowledgement that our role as community psychologists forms part of a broader action and that we are mindful as we enter ongoing development processes, which do not begin with our interventions. Lastly it also entails thinking about how the results our interventions can sustain themselves after we are gone. The next chapter examines the application the psychoanalytic framework on community psychology, groups and organisations.

## **CHAPTER THREE**

### **APPLICATION OF PSYCHODYNAMIC THEORY TO COMMUNITY BASED INTERVENTIONS**

#### **3.1 Introduction**

This chapter will discuss the application of psychoanalytic theory to community psychology, groups, and organisations. In addition it explores the theoretical understanding of trauma and the concept of re-enactment (repetition). The last section examines the underlying dynamics of race and gender and how they are re-enacted in relationships.

#### **3.2 Basic concepts of psychoanalysis**

Freud is recognised as the father of psychoanalytic theory, which he began to develop in the late 1890s as a technique for understanding the mind and its influence on motivation and behaviour (Brown & Pedder, 1991; Ward & Zarate, 2000). Psychoanalysis consists of two major assumptions that will be discussed below, namely the existence of the unconscious and the importance of the past in the development of the unconscious and of defence mechanisms.

##### **3.2.1 Unconscious processes**

Freud argued that unconscious process is a hidden aspect of the human mind and that it is 'dynamic'; constantly active in influencing our thoughts and behaviour (Brown & Pedder, 1991; Mitchell & Black, 1995; De Board, 1995; Ward & Zarate, 2000). The dynamic of the unconscious is represented through slips of the tongue, dreams, forgetting, and through 'repression'. Freud argued that, through an interpretative therapy, unconscious processes could be made available to the conscious part of the mind. Freud initially used free association and dreams as way to gain insight into unconscious processes. He believed that the contents of the

unconscious reflected early drives and patterns of relating. Patterns of relating are formed during early childhood and become the template that adults use to make sense of the world and interact with (Brown & Pedder, 1991; De Board, 1995). The link between unconscious processes and past experiences lies in the way in which the latter is reflected in one's current conscious behaviours and motives. This reflection is understood to be a repetition of past experiences and Freud understood this repetition to be compulsive.

### **3.2.2 Defence mechanisms**

A psychological defence mechanism is a strategy in which the mind employs to manage and defend itself against overwhelming unconscious motivations and desires which would otherwise cause unbearable anxiety in our daily lives. These mechanisms include withdrawal, denial, repression, regression, devaluation, projective identification, introjection, projection and splitting (Brown & Pedder, 1991). According to Brown & Pedder (1991) and Halton (1994) defence mechanisms may be either mature (healthy) or immature (unhealthy/primitive). The maturity or immaturity of a defence mechanism is judged its adaptive or maladaptive nature (Brown & Pedder 1991; Halton, 1994). Like the contents of unconscious processes, the ways in which an individual's patterns of defence mechanisms develop is influenced by childhood experiences.

In chapter two I have argued that the application of psychoanalytical approach in its 'purest' form, particularly in a community setting, has been questioned by authors such as Long (2002), who argue that psychoanalysis has to be applicable to the context in which it is used. In this research therefore the term psychodynamic is used rather than the term psychoanalysis. Although the psychodynamic theories are based on the psychoanalysis' concepts that are discussed above, the psychodynamic approach acknowledges the broader context of a community intervention.



### **3.3 Application of psychodynamic theory to community psychology**

It has been argued that psychodynamic is a useful theoretical framework and its potential, particularly as a 'social-psychological theory', has been acknowledged (Gibson, 2002a). Psychodynamic theory has also been used to understand dynamics within groups and organisations and is "relevant in the practices of community consultation" (Gibson, 2002a, p.35). Because of these strengths, I have chosen to use it as a theoretical framework for this research. In addition, my training at the CGC was informed by the psychodynamic principles which also guided our intervention at the CBO.

Despite the contradictions and debates which characterise the relationship between psychodynamic theory and community psychology, there is increasing recognition that this theory offers a "different understanding of social processes ... and connects with the issues that community psychologists were struggling with: oppression, racism and colonialism" (Gibson 2002a, p.36). However, it is important to note that some local authors have been concerned about the appropriateness of a psychoanalytic approach in a South African context where there are many political and social realities competing for few resources (Anonymous, 1986; Maw 1996; Gibson 2002a). It may be argued that the psychoanalytic perspective focuses on the individual to the exclusion of the social and political context (Mitchell & Black, 1995). Long (2002) suggests;

psychoanalysis can only be used effectively in community settings when it explicitly recognises socio-political influences and includes these object-worlds of our clients. Without recognition of the interplay of power in a variety of dimensions, and without recognition of issues of difference between client and practitioner, the intervention may be limited or even harmful (p.113).

There is a paradoxical relationship between psychodynamic framework and community psychology because each focuses on different a level. Psychodynamic is focused on a micro level

(individual), whilst community psychology is focused on a macro level which includes the context. I was particularly struck by this paradox in my work at the CBO. This research seeks to understand trauma at an individual level and how the organisational context contributed to that trauma. The psychodynamic framework combined with systems theory (discussed in chapter two) can therefore help to explain the micro and macro issues that emerged in my work with the community health workers at the CBO. Further, there is extensive and significant psychodynamic theory on group and organisations that this research can draw on.

### **3.4 Application of psychodynamic to groups and organisations**

The study of human behaviour in groups and organisations established itself strongly after the 1930s, before this it was not regarded as an important area of research (De Board, 1995). Since then there have been many theorists and pioneers who have made a significant contribution to this field. According to Bennett (1994, p.3);

the study of organisational behaviour concerns the study of how organisations function and how people relate to them through their conduct, perceptions and intentions – individually or in groups. As an academic principle, organisation behaviour draws heavily on the social and behavioural sciences and on the theory of organisation design.

The early studies of original thinkers such as Weber (1930), Lewin (1924), Freud (1912, 1922) and Mayo (1924) have played a critical role in informing current studies and have contributed significantly to the growth of research on groups and organisations (De Board, 1995; Bennett, 1994).

It has been argued that the psychodynamic paradigm has made a valuable contribution to the understanding of organisational thinking and functioning (Halton, 1994). This is because it allows us to apply to organisations the study the “inner world of the individual with its dynamic

processes of fragmentation and integration” (ibid, p.18). An approach to organisational work which is based on a psychodynamic framework, extends the concepts of the unconscious and defence mechanisms in order to better understand the organisation’s emotional life (Halton, 1994). Thus, for instance, an understanding of defence mechanisms applied to an organisation enables us to observe how that organisation is dealing with anxiety and engaging with reality. Citing Jacque (1995), Foster & Roberts (1998) note that it is not only anxieties, but also disorganised systems, that cause dysfunction in an organisation. Similarly, Obholzer (1994) suggests that authority, power and leadership are usually not well understood within organisations and result in confusion and distress; *authority* is a right to make decisions that affect others; *power* is an “ability to act upon others or upon organizational structure” (p.42); *leadership* is an ability to pursue goals and look to the future.

Although psychodynamic theory focuses fundamentally on the individual psyche, Freud, Ferenczi and Bion have pioneered the study of understanding the behaviour of people in groups (De Board, 1995; Bennett, 1994). Psychodynamic theory has thus assisted us in understanding and predicting human behaviour in groups or organisational settings. Such seminal thinkers as Klein (1959) and Bion (1961) in particular, have played a critical role in informing the development of recent psychodynamic organisational theory. I will now discuss these briefly.

#### **3.4.1.1 Klein**

Even though Melanie Klein “did not extend her interests to groups or social processes but remained focused on the individual”, her work has been extended to groups and organisations (Gibson, 2002a, p.41). Bion (1961) recognised the value that Klein’s concepts could add in the analysis of group and organisation dynamics (De Board, 1995).

Klein conceptualised human development as consisting of two major stages: paranoid-schizoid position and the depressive position. These two positions are central to the life-long struggle each person engages with as they move between these two states in an attempt to master relationships.

The paranoid-schizoid position is characterised by splitting and projective defence mechanisms, which are employed by a person to avoid pain. In this position defence mechanisms are used as a way to ease and gain relief from overwhelming painful and unbearable emotions by splitting them off or externalising them (Klein, 1985; Halton, 1994). Projection refers to the process whereby a person places her/his feelings onto another person, thereby disavowing the feelings.

The second stage of human development, the depressive position, is characterised by a need in the individual to integrate conflicting feelings such as love and hate, rejection and acceptance, and to be able to deal with the ambivalence posed by these conflicting emotions and to accept their co-existence (Klein, 1985; Halton, 1994; De Board, 1995). This is regarded as a more mature position than the paranoid-schizoid position. This position involves a clear attempt by the individual to integrate internal and external reality.

#### **3.4.1.2 Bion**

Wilfred Bion (1961) is regarded as a “major contributor of unconscious processes in groups” and organisations (Stokes, 1994, p.19). While working as an officer in the British army during World War II and treating various ‘war neuroses’, Bion decided to use the “organisation (hospital) itself as a therapeutic modality” (Lofgren, 1984, p.203). He formed small therapeutic groups as an intervention. His results encouraged him to further his understanding of group dynamics and later he started running small groups at the Tavistock clinic in London (Lofgren, 1984, Stokes, 1994; De Board, 1995).

Drawing on the paranoid-schizoid and the depressive positions. Bion (1968) developed Klein's concept of projective identification, to "complete and underpin his theory of groups, seeing them not only as individual but also as group phenomena" (De Board, 1995, p.45). The concept of projective identification suggests that individuals share aspects of one another through projection (Gibson, 2002a). That is, a person who has had feelings projected into them tends to unconsciously identify with these feelings (Halton, 1994). The process through which the other person's feelings are experienced is called counter-transference. In a therapeutic space counter-transference is the analyst's experience of analysand's story and the way she/he relates it. Together with projective identification, counter-transference offers a tool to understanding the unconscious processes of the organisation and its defences (Halton, 1994).

#### **3.4.1.3 Bion's 'basic assumption' states**

Through his work with groups Bion suggested that group dynamics consist of tensions between two states: the conscious aspects of working towards the primary task of the group, and the unconscious aspect that includes the avoidance and sabotage of the primary task. Bion referred to the latter as a 'basic assumption' (*ba*) mentality (Stokes, 1994). The tension between the two mentalities is linked to the tensions between a group's attempt to "face and work with reality" and its attempt to avoid pain "or psychological conflict within or between group members" (ibid., p.20).

The group's behaviour during the basic assumption state is marked by chaos and irrationality. This state is an unconscious aspect of group functioning and remains hidden until the group is directed towards these emotions (Lofgren, 1984; Stokes, 1994). In addition, the basic assumption state gives rise to a particular complex of feelings, thoughts, and behaviour.

In basic assumption mentality, the group and its leader lose their capacity to think or be effective, and the focus shifts from the task to the interactions within the group and “the formation and continuance of the group becomes an end to itself” (Stokes, 1994, p.26). In an organisation Bion’s theory seeks to describe how individuals become part of a shared culture and share similar defence mechanisms.

It is clear that psychodynamic has contributed significantly to the understanding of conscious and unconscious group and organisational dynamics. Using a psychodynamic approach, Obholzer & Roberts (1994) and Gibson (2000a) argue that organisations experiencing difficult periods tend to react in a similar way to individuals under stress. In an attempt to avoid pain they adopt unhealthy defence mechanisms that “obstruct contact with reality” (Halton, 1994, p.12). Gibson (2000a) argues that stress seems to overturn the organisation’s own stated goals and interests as well as their ability to develop through the consultation process.

In the following sections I will build on the psychodynamic foundation, discussed above, using self-psychology and intersubjectivity theories to understand group and organisation dynamics.

### **3.5 Application of self-psychology to groups and organisations**

Before I begin to show how self-psychology can be applied to groups I will discuss the key aspects of the theory that are relevant in this research.

Kohut (1971), the pioneer of self-psychology, differed fundamentally from those who had come before him, including classical psychoanalytic theorists such as Freud and Klein. Self-psychology theory perceived ‘the experience of self’ as primary to human development and at the “center of psychoanalytic inquiry” (Stolorow, 1984, p.48). (See also Mitchell & Black, 1995; Ward &

Zarate, 2000). The experience and development of self takes place in the 'self-selfobject matrix', which is a specific kind of 'interaction in the interpersonal field' (Teicholz, 1999, p.40). A matrix of selfobjects initially involves only the primary caregiver and the infant, but later could also include objects that the infant becomes attached to, such as toys, friends, and other adults in her/his life (Teicholz, 1999).

The way the self experiences itself in the self-selfobject matrix is very important because the outcomes are internalised and preserved in the psychic structure (Swartz, 2000). For instance, when the idealising needs are met the self develops the capacity to self-soothe, because she/he has internalised the qualities of the idealised object. In this way a person is able to develop matured and adaptive self-defence mechanisms. On the other hand, when there is a failure in the selfobject experience, through for example trauma or deprivation, the self builds a maladaptive defence structure to control the anxiety. The selfobject experience is thus a link between self and others, and includes the empathic response of the caregiver, or in some instance the failures of the caregiver to respond to the need of the child (Stolorow, 1984; Basch, 1984; Swartz, 2000).

There are three selfobject experiences that are critical in the development of a cohesive self: mirroring, idealising and twinship selfobject transferences or experiences:

- The mirroring selfobject experience provides the child with an empathic and appropriate response to her/his 'grandiosity'. The archaic mirroring selfobject need includes both primitive grandiosity and a sense of entitlement. The mature mirroring selfobject need involves recognition and acknowledgement.

- The idealising selfobject experience forms part of a need to be related to as a strong and admired selfobject. The selfobject could be a primary caregiver in the early years, and later on friends or mentors. Even an ideology could fulfil a selfobject need (Teicholz, 1999; Swartz, 2000).
- The twinship selfobject experience that Kohut (1971) proposed is the need for one to be like one's parent of the same sex.

Each of these selfobject needs is important, initially for the development of self-structure and later in life for the maintenance of a cohesive self. The development of these selfobject experiences influences the pattern of the future relationships (Teicholz, 1999; Swartz, 2000). During stress a cohesive self is able to remain functional but a fragmented self's basic self-regulatory structure is significantly affected and is not be able to cope (Lofgren 1984; Swartz, 2000).

Lofgren (1984) argues that the functioning of the cohesive self can assist us to understand group dynamics and processes. Citing Stone and Whitman (1977), he points out that groups have shown needs for mirroring and these have led to behaviours which reflect mirroring, twinship and idealising transferences. Lofgren (1984), using the Tavistock training group as an example, showed that continuous lack of empathy and failure to meet idealised expectations by the leader resulted in a narcissistic injury and rage in the group. According to Kohut (1971, quoted in Lofgren, 1984 p.207), "the self exposed to regressive pressures in the form of narcissistic injuries is liable to fragmentation." This fragmentation comes in different forms and depends on the cohesiveness of the self (Lofgren, 1984; Swartz, 2000).



Furthermore, application of Bion's 'basic assumption' concept suggests that the chaos and irrational behaviour of a group is also linked to narcissistic injury. For instance, in a basic assumption mentality group members are fragmenting and experiencing low self-esteem and there is longing for a selfobject to reinstate cohesiveness to the self. In this state the unavailability and lack of empathy of the leader causes a narcissistic injury to group members (Lofgren, 1984). Lofgren's ideas and arguments provide a useful approach to understanding the behaviour of group members and their expectations of their leader.

### **3.6 Application of intersubjectivity theory to groups and organisations**

Although there is only a limited body of literature on the contribution of intersubjectivity theory to the study of groups and organisations, local contemporary writers – as mentioned above – are beginning to apply its framework in community psychology. Intersubjectivity theory is seen as consisting of diverse ideas, approaches and techniques (Aron, 1996, 1997, 1998; Mitchell, 1993, 1997, 1998; both cited in Gerhardt, Sweetnam & Borton, 2000). This literature review draws on these different arguments, but discussion is limited to those aspects of each theory which are seen as relevant to this research.

Stolorow, Brandchaft and Atwood (1987) introduced the term intersubjectivity into psychoanalytic theory (Benjamin, 1990). Intersubjectivity theorists such as Stolorow and Atwood have argued that their theory is about "the larger relational system or field in which psychological phenomena crystallize and in which experience is continually and mutually shaped" (Stolorow, 1995, p.393). They have incorporated Kohut's seminal theory but, instead of focusing mainly on the self, they consider "the fully contextual interaction of subjectivities with reciprocal, mutual influence" as fundamental to psychological development and a therapeutic milieu (Mitchell & Black, 1995, p.167). This concept of 'reciprocal mutual influence' within intersubjectivity theory

highlights the connectedness of an individual's inner world to the world of others. In addition, the concept suggests that there is a 'continuous flow' and constant interaction between two or more intersubjective experiences. Intersubjectivity theory suggests that psychological functioning develops within an intersubjective milieu (Stolorow, 1995; Mitchell & Black, 1995). Benjamin (1990) takes this a step further by arguing that psychological development takes place both in the intrapsychically and intersubjectively.

Benjamin's intersubjectivity theory (1990) is different from that of other theorists in this field. Firstly she suggests a new approach by bringing together feminist studies and intersubjectivity theory (Mitchell & Aron, 1999). She criticises the psychoanalytic model, particularly development theories such as self-psychology, for excluding the subjectivity of the mother and for concentrating only on the infant's needs. She refers to these theories as 'infantocentric', because they failed to recognise that the infant not only receives empathy but also provides it for the mother. In this instance the relationship is unidirectional. Benjamin (1990) further argues that the acknowledgment of the needs of a mother is critical, and central to the development of the self. Recognising that the mother is another subject with different needs and wishes means that she is seen as an equal in the dyadic relationship. Thus Benjamin (1990) defines intersubjectivity as referring to "that zone of experience or theory in which the other is not merely the object of the ego's needs/drive or recognition/perception, but has a separate and equivalent center of self" (p.186).

Secondly, Benjamin (1990) argues that by acknowledging a mother as an equal subject, we have to address the difficulties raised by the "troublesome legacy of intrapsychic theory, the term 'object' " (p.184). Traditionally, the term 'object' has been used to describe the self's internalisation and experience of its interaction with the other. The term 'other' is however used

by Benjamin to refer to the “real”, the subject that is outside of the self (Gerhardt, Sweetnam & Borton, 2000). Naming the mother as a subject does not replace her function as an ‘object’, but instead acknowledges that both have a role in self-development. Benjamin’s (1990) theory distinguishes these two modes of relating from each other, and regards them as equally important and occurring simultaneously. The modes complement each other rather than contradict each other. The ‘object’ represents the intrapsychic mode of relating that is influenced by the unconscious processes, while the ‘other’ is based on intersubjective relatedness (Gerhardt et al., 2000). For Benjamin (1990) it is not only object *usage* that is important in the development of self but also object *relating*. Her explicit incorporation of the intrapsychic mode into intersubjective theory is useful because it explains the continuous impact of the psychic structure on self-experience and on relationships with others (Gerhardt et al., 2000).

As noted above, intersubjectivity theory is comprised of diverse views, however the acknowledgement of the analyst’s presence, and the way in which she/he consciously or unconsciously shapes the intersubjective field, is the common feature amongst all intersubjective theorists (Gerhardt, et al, 2000). This presence is explained in various ways that include counter-transference, projective identification, impressions and feelings. All these provide a foundation within which both the analyst and patient co-create in the analytic space. Stolorow, Orange & Atwood (1997, p.720) refer to this as a “mutually constitutive interplay between the organising activities of patient analyst.” Stolorow (1995) argues that it is not sufficient to identify a patient’s experience of the disruption and failures in the ‘selfobject transference’ but says that it is also necessary to investigate and highlight the way in which the patient’s and analyst’s experiences are unconsciously organised, and how they interact with each other. This colliding of organising principles between patient and analyst is the focal point of intersubjective theory (ibid.).

Stolorow (1995) argues that the interaction between the patient's and analyst's psychological worlds produces two states, which he calls 'intersubjective conjunction' and 'intersubjective disjunction'. Intersubjective conjunction occurs when the underlying beliefs of the patient's experiences are expressed in such a way that they appear to be similar to aspects of the analyst's psychological life. Intersubjective disjunction occurs when the analyst internalises information from the patient in a way that significantly changes its meaning.

These two states are inherent to the therapeutic process and describe the dance between the patient's and analyst's psychological worlds. Thus it becomes imperative for the analyst to reflect continually and to investigate her/his own organising principles and experiences; "When the analyst is able to become reflectively aware of the principles organising his experience of the therapeutic relationship, then the correspondence or disparity between the subjective worlds of patient and analyst can be used to promote empathic understanding and insight" (Stolorow, 1995, p.398).

Continuous interrogation of the analytic experience, revisiting of, and reflection on the material presented by the patient, in order to understand and draw meaning also reflects the subjective-intersubjective experience. That includes the analyst's consideration of the values and belief system that she/he uses to make meaning (Aron, 1999; Gerhardt et al., 2000). Gerhardt et al., 2000 (p.8) say:

The analyst-patient relationship is thus theorised as more than just an interpersonal encounter conditioned by the forces of mutual reciprocal influence, and reflects a collapse of analytic space when it is. Instead, the dyadic encounter is triangulated by a third mediating voice.

A third voice could be the conscious and unconscious processes of the analyst. In the literature there is growing acknowledgement that the analytic encounter between analyst and patient is embedded in a unique context (Gerhardt et al, 2000). Aron (1999), building on the work of Ogden (1994), Spezzano (1998), and others, argues that there is a need to acknowledge that the dyad does not exist in a vacuum. Aron (1999) recognises the influence of the broader social, cultural, and historical context on the encounter. In addition, he argues that the psychoanalytic framework is in itself a system of beliefs and values which will influence the way in which the analyst engages with the patient's and material the patient brings.

Intersubjective theory provides another lense through which to consider organisational settings. Aron (1999) suggests that it is helpful to view the theory of psychoanalytic method as consisting of a range of interrelated guidelines for assessing and understanding behaviour within a unique relational milieu.

### **3.7 Conclusion**

The basic concepts of psychodynamic theory are applicable to groups and organisations. In the literature they have been extended and developed in order to understand the psychological functioning of groups and organisations. The application of self-psychology theory to groups and organisations is embryonic at this stage, but the initial ideas suggested thus far are worth considering. Intersubjectivity and self-psychology theories and community psychology seem to complement each other. They focus on the interface between individual and its environment. On the one hand, community psychology seeks to understand the way in which an individual internalises and make meaning of her/his social and political context. On the other hand, intersubjectivity and self psychology theories are concerned with the relational system and the way experience of an individual is continually shaped and influenced by others. There is a

connection between the individual's inner world and that of others. The use of these theories may help to elucidate both micro and macro dynamics within an organisation.

### **3.8 The application of psychodynamic to the understanding of trauma**

The aim of this research is to explore the re-enactment of trauma in a community-based organisation. So far I have discussed the literature on community psychology and organisations, and the application of psychodynamic theory to community psychology and our understanding of organisations. In the next section I will examine the theoretical understanding of trauma and its re-enactment. The last section provides a brief overview of the construction of race and gender, and the way in which they impact on initial to or experience of trauma and later the repetition.

#### **3.8.1 Definition of trauma**

Starting with Freud himself, ideas about the definition and causes of psychological trauma have changed and developed over the years, yet trauma has remained the “pillar of psychoanalytic thought” (Stolorow and Atwood (1992, p.51), which has provoked a great deal of debate and discussion (Mitchell & Black, 1995; Brothers, 1995; Herman, 1997).

Laplanche & Pontalis (1980), psychoanalytically define trauma as “an event in the subject's life defined by its intensity, by the subject's incapacity to respond adequately to it, and by the upheaval and long-lasting effects that it brings about in the psychical organisation” (p.465). This definition highlights the subjective experience of trauma, which challenges the more generally accepted definition of trauma as something which can be objectively defined and is usually an outcome of a single event that happens unexpectedly (Moultrie, 2004).

This more general definition is not usually applicable in South Africa where violence impacts frequently on lives through socio-political and economic deprivation (Evans & Swartz, 2000). Thus, trauma is insidious and embedded in one's race, gender and class. Swartz (2004, p.4) argues that the definition of trauma in South Africa is compounded by "the ongoing assault of class and race conflict." The slow pace of transformation in South African institutions is maintaining and even reinforcing the racial imbalances created by apartheid systems and policies. As a result, post-apartheid society remains deeply scarred by racial segregations and power imbalances, which tend to repeat history (Swartz, 2004). Herman's argument of political trauma provides a deeper understanding of what Swartz (2004) has argued. Herman (1997) suggests "the methods of establishing control over another person are based upon systematic, repetitive infliction of psychological trauma. They are organised techniques of disempowerment and disconnection. Methods of psychological control are designed to instil terror and helplessness and to destroy the victim's sense of self in relation to others" (p.77).

Contemporary psychoanalytic theory therefore suggests that it is the subjective experience of trauma event that is traumatic rather than the event itself. In addition, in South Africa trauma is directly related to the impact of socio-political context. Bearing this in mind, I now turn to the psychodynamic theoretical contributions has given in our understanding of the way in which trauma evolve.

### **3.8.2 Theoretical contributions to an understanding of trauma**

Amongst contemporary psychodynamic theorists the definition of childhood trauma has shifted from "a single, cataclysmic childhood event" to "the parents' chronic failure to meet the psychological needs of the developing child" (Mitchell & Black, 1995, p.209). Similarly self-psychology understands trauma as a result of failures in selfobject experiences; trauma is

understood as negligence in preserving something that is good and constant failure of the environment to produce a healthy psyche (Mitchell & Black, 1995). This argument departs completely from Freud's view that trauma is an expression of intra-psychic conflicts and primitive impulses and foregrounds the "chronic milieu of the patient's early human environment" (p.163).

Brothers (1995) argues that traumatic events shatter the structure of the self and that "trauma can only be understood as the betrayal of trust in the self-object relationship on which selfhood depends" (p.55). That is, the betrayed trust is the heart of trauma, since trauma and trust are fundamentally linked. She further argues, in a similar vein to Laplanche & Pontalis (1980), that trauma is not inherent in the event itself but resides in the unconscious meaning given to the event. She notes that survivors tend to disavow traumatic events and that what is disavowed is the fragmentation of the trust that existed between the self and the selfobject. Similarly Herman (1997) describes the impact of trauma as follows:

Traumatic events call into question basic human relationships. They breach the attachment of family, friendship, love and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience... Traumatic events have primary effects not only on the psychological structures of self but also on the systems of attachment and meaning that link individual and community (p.51).

In order to avoid overwhelming fragmentation, the survivor of trauma must adjust her/his experiences of subjective reality so that self and/or others can be trusted, despite the traumatic event. However, as the meaning of traumatising betrayal is disowned, the subjective reality is adjusted, as is the survivor's organisation of self-trust (Brothers, 1995). In this way the betrayal of trust creates a disturbance in the way others are trusted. Betrayal of trust shatters the psychical



structure and interrupts the continuity of self-development. In addition, the behaviour of the survivor is altered.

The intersubjectivists, such as Stolorow and Atwood (1992), argue that the fundamentals of trauma are embedded “in the unbearable affect” (p.52) and that a traumatic affect has to be understood in terms of the relational milieu in which it happens. For example, a child’s affect state is the product of a child-caregiver system (ibid.). Trauma is the result of the collapse of the “child-caregiver system of mutual regulation” (ibid., p.53). There is an experience of selfobject failure when there has been a failure of affect attunement. As a result of this failure, child losses her capacity to regulate her/his affect and the self becomes overwhelmed and disintegrates under severe stress (ibid.).

As highlighted in Chapter Two apartheid regime in South Africa created structural conditions that were, and still are, traumatic to society. Thus trauma in South Africa is not a discrete event but is located within the greater socio-political and economic context. Any community intervention which denies these power imbalances have the potential to create enormous pain and distress to the people they are trying to assist. As Swartz (2004) argues, we have to acknowledge what we bring into a therapeutic relationship, and this includes our own race, gender, and class. In addition, she suggests that any intervention in a post-apartheid society must take cognisance of the way in which trauma has internalised.

### **3.8.3 Theoretical framework and repetition of trauma**

Repetition of trauma or retraumatisation occurs when the current event is a reproduction of the previous trauma (Stolorow & Atwood, 1992). Repetition or re-enactment of trauma is described in the literature as something that an individual does not have control over; trauma happens on its

accord and cannot be avoided (Herman, 1997). Russell (1999a) suggests that our lives cannot progress without repetition and it is beyond an individual's control. There is always a compulsion to repeat. Russell describes this as something "spooky" and he says, "we seem to be dealing here with some internal, systematic error that eludes our perception and control" (p.2). Despite the frequent repetition of these behaviours, human beings do not seem to learn from experience to avoid or anticipate future actions or reactions, and instead continue to repeat the patterns of the past (Herman, 1997; Russell, 1999a). People repeat behaviours because of the way they feel (Russell, 1999a). Although we repeat the parts of our lives that we enjoy, we also repeat the parts that we would seemingly prefer not to. It is this painful experience of repetition that patients bring to an analytic process (Russell, 1999a). It is the repetition of painful patterns which is focused on in the literature.

According to Stolorow & Atwood (1992), repetition of trauma is "a confirmation of the organising principles that resulted from the original trauma, or the loss or disruption of a sustaining bond that has provided an alternative mode of organising experience, without which the old invariant principles are brought back into the fore" (p. 56). Other writers describe it as a "mute language" (Herman, 1997), and as symbolising something that happened before that has not been articulated (Gobodo-Madikizela, 2003). Swartz (2004) describes it as a form of unconscious communication which reflects an emotional need on the part of the survivor to be heard and to repair her/his psychic injury. These arguments suggest that repetition indicates that there was some form of obstruction in the process of early development that affected maturation. In repetition there is also an attempt to repair the injury or to master the unresolved feelings of trauma (Herman, 1997). Russell (1999a) suggests that repetition is a "reminder that we have not yet found a way to feel differently" (p. 21). Hence repetition of trauma, particularly in the

analytic relationship, presents an opportunity for change (Stern, 1994; Stolorow, 1995; Herman, 1997; Swartz, 2004).

The repetition of trauma offers hope for working through early wounds and for altering the principles which organise our experiences. Paradoxically with repetition comes the desire to move on and to lay the memory of trauma to rest. There is also, however, a direct link between repetition of trauma and resistance and transference (Swartz, 2004). The literature shows that it is not possible to forget a traumatic event, although the survivor wants to forget rather than work through the trauma. Gobodo-Madikizela (2003), in her account of her experience of working with the victims of atrocity in South Africa, argues that some survivors were reluctant to open up and “claimed that they [had] laid their trauma to rest” (p.85). However, when these survivors shared their stories it was clear that the traumatic event was alive and present. For example, describing the trauma of one of the survivors, Gobodo-Madikizela (2003, p.89) states, “the event seemed so vivid to me that it was as if it were happening in the moment... an illustration of the timelessness of traumatic pain.” Swartz (2004) also argues that psychic trauma is not short-lived or transitory but is always “available and will repeat”. She does, however, add, “It is in the shaping of successive repetitions that [psychical trauma] may change its dimension and offer a form of restitution” (p.7). It thus seems that there is no way to work through trauma except through the process of repetition. Yet there is also a wish to remain the same, and Russell (1999a) argues that this is the paradox of repetition compulsion.

Russell (1999a) refers to the continuous tension between the continuity of old patterns and the change to new patterns as a paradox, which is at the heart of human growth and characterises analytic relationships. Repetition takes place within relationships and therefore it is important for the analyst to note the kind of relationship within which the person repeats. Russell (1999a)

further suggests that, in order to understand the repetition, the following patterns should be observed: “around whom, with whom and through whom they repeat” (p. 4). He suggests four questions which are at the centre of the paradox and encapsulate the desire for continuity through relationships: (1) “Is it me or is it you?” (2) “Did I do this, or was it done to me?” (3) “Is it now, or was it then?”, and (4) “Can I choose what I feel?” (ibid., p.8). In an effort to address the past, these questions become important because they help the patient to differentiate what they are doing from what is being done to them. Mitchell (1999) argues that it is impossible to separate ‘me’ from ‘you’ at the critical points of growth and intense experience of emotions because some regression takes place to the level where these rules are not applicable. Therefore, the paradox remains because it is very difficult to draw a line and the role of the therapist is to help patients manage this paradox.

Russell (1999a) suggests that it is not only the paradoxical behaviour of the patient that can obstruct the analytic process but that of the therapist as well. Like the patient, he argues, the therapist also resists change and struggles to feel what the client feels. He refers to this occurrence as a transference-countertransference enmeshment and argues that the analyst’s transference and counter-transference do not consist only of the response of the patient but also come from the analyst’s past. Russell (1999a) suggests that the therapist’s compulsion to repeat forms part of this enmeshment. He suggests that these earlier patterns of the therapist become intertwined with those of the patient and become part of the analytic process. Hence, it is important for the therapist to be able to be in touch with what she/he feels, otherwise she/he runs the risk of retraumatizing a patient. The analyst must play two roles: that of the person who failed the patient, as well as that of a different person who provides a possibility for a new relationship. This involves affect negotiation in the analytic space and depends on both the analyst’s and patient’s abilities to feel. Russell (1999a) argues that “there is no real treatment process that does

not include some piece of therapy for the therapist” (p.17). The analytic relationship involves the emotional growth of both patient and analyst.

#### ***3.8.3.1 Intra-intersubjective internalisation of race and gender***

Some of the literature reviewed so far highlights race and gender as salient features in most, if not all, interpersonal encounters, particularly in a South Africa context. Race and gender informs the way people relate to each other and it is arguable that there is also a compulsion to repeat the patterns from the, apartheid, in post-apartheid society. It is therefore useful to provide a psychodynamic discussion on the construction of race/gender, which is central to this research. For this section I will be drawing on the work of Flax (2004). Although her writing is based on American politics, the dynamics of race that she raises are very similar and relevant to the South African context. She regards race/gender as one thing and indivisible. She argues that race/gender pervades every aspect of our society and that there is “no ungendered raced subject and no unraced gendered one” (Flax, 2004, p.2).

In South Africa race relations have remained a highly charged area, and despite democracy and ‘liberation’ they seem to remain impervious to change. Maw (2002) gives an example showing how race/gender affected her consultation relationship as well as the relationship between her consultee and her consultee’s colleagues. According to Flax (2004), the removal of overt discriminatory systems will not necessarily eradicate the negative impacts of race/gender on our society. Race/gender is constructed both intrapsychically and intersubjectively; the formation of race/gender is located both within and outside an individual. A solution to the race/gender issues will continue to elude us unless we deconstruct their intra- and intersubjective development.

Flax (2004) argues that in order to address gender/race, we must first recognise the connectedness of the psyche and intersubjectivity, and their power in maintaining and re-enacting race/gender dynamics. She adds, “deconstruction cannot occur without admitting that a particular set of relations was constructed. We cannot just pretend that race/gender does not shape us, that we can operate simply as (rational) individuals” (Flax 2004, p.24). What I have attempted to show through the literature review and what Flax is arguing is that it is impossible to achieve innocence particularly in therapeutic relationship. That is, it is impossible for an analyst to enter a therapeutic relationship ungendered or unraced, as these form part of an analyst’s identity.

In her paper Flax (2004) uses the terms ‘racialised’ when referring to non-white people and the word ‘privileged’ for whites. Using Winnicott’s (1971) concept of transitional space and Cheng’s (2001) phrase ‘melancholy of race’, Flax (2004) shows how racialised and privileged subjects use projection, splitting, and denial to interact with each other. These defence mechanisms are maladaptive and are used to suppress anxiety and gain relief from the unbearable feelings raised by the way in which subjects experience each other. For instance, the privileged subject’s construction of the racialised subject involves undermining and demeaning the other, and then internalising this. In order to do this, privileged subjects idealise themselves while devaluing racialised subjects by projecting the problematic aspects of the self onto the other, thus allowing the self to be idealised. By way of example, Flax (2004) states, “feelings of insecurity about one’s own skills can be turned into contempt for the supposed lacks of a whole group (e.g. blacks are not as smart as white people)” (p.9). So the racialised subject becomes a ‘bad object’ and they themselves become a ‘good object’. This intrapsychic processes is then translated into reality and the privileged subject uses their location on the ‘grid of power’ to make this idealisation seem real. The idealised image informs legislations and distribution of resources, as was done during the apartheid era in South Africa.

The racialised subject, on the other hand, is in a double bind. Her/his position on the power grid is predetermined, and accepting the self-created image of the privileged is painful to her/his pride and is traumatic. Trying to achieve the idealised image of the privileged is impossible because it is not real and is based on a fantasy. This validates the denigration by the privileged, which the racialised subject then internalises. Flax (2004) argues, “thus for the racialised subject, melancholia is the condition of having to encrypt both an impossible ideal and a denigrated self” (p.9).

Attempts at undoing the internalisation of race/gender becomes complex because both subjects are defended (using defence mechanisms) in the way they engage with reality and relate to each other. For the privileged subject to do this, she/he must acknowledge the wrongs of the past (and present). This includes her/his recognition of the internalised racial other, as well as a dependency on the devaluing of others, which she/he has embraced and made a part of self. This undoing may become unbearable for the privileged and can pose a threat to the stability of her/his psyche and their social world. As a way of avoiding the resulting collapse of psyche and social world, both the internalised other and the harm one has done to it (including actual physical harm) are denied. This denial suppresses anxiety and prevents grieving from occurring. The devaluation of the racialised subject is disavowed and thus no longer part of the privileged subject’s consciousness (Flax, 2004).

According to Bollas (1992), denial is the individual’s desire “to be innocent of what is often most troubling” (p. 167). In this case, to maintain her/his ‘innocence’, the privileged subject positions the racialised subject as a devalued other on the one side of the continuum. In this way the re-enactment of devaluing dynamics continues (Flax, 2004). The denial is toxic and destroys race relations. The applicability of these conceptualisations in terms of the South African context is

noteworthy. South African history continues to be plagued by power imbalances which were the foundation of the apartheid system (Maw, 2002; Long, 2002; Gibson, 2002b). Flax's (2004) argument that racialised subject formation continues to exist is applicable to the South African context.

### **3.9 Summary**

Classical theorists such as Klein and Bion have made an invaluable contribution to the understanding of groups and organisations. Contemporary theories such as self-psychology theory offer some new perspectives and ideas how organisations can utilise the concepts of mirroring and idealisation to create cohesive groups and appropriate leadership. Intersubjectivity theory also provides an understanding of the relationship between an individual and her or his context at a micro level in an organisation.

Re-enactment of trauma, particularly in South Africa, is embedded in the personal and political experience of the survivor. These dimensions cannot be separated. Intersubjectivity theory arguably offers a better understanding of the impact of trauma in South Africa than that offered by classical theory, because it acknowledges the interaction of experiences between people. Most importantly it provides the possibility of understanding how race, gender and class interact intersubjectively. Its emphasis on the intersubjective field acknowledges that the analyst is not 'innocent' but also carries their own baggage with regards to race, gender and class.

In a South African context, mental health professionals cannot deny that they are shaped and influenced by race/gender. Assuming innocence becomes dangerous as well as damaging because our sincere intentions to 'help' deny the issues of power, conflict, gender and race that underlie these interventions. Thus self-psychology and intersubjective theories take a step further in



psychoanalytic literature because they acknowledge the power imbalances and their impact on the relational milieu.

Having reviewed the theoretical arguments relevant to this research, I now turn to the methodology that was used to explore the way in which the imminent closure of the CBO repeated past trauma both at micro and macro levels for the community health workers.

University of Cape Town

## **CHAPTER FOUR**

### **METHODOLOGY**

#### **4.1 Introduction**

This chapter discusses the methodology that was used in order to explore the reaction of the community health workers to the imminent closure of the CBO. It also looks critically at the methodology itself in order to highlight its advantages and limitations.

#### **4.2 Context and background**

In order to explore the reaction of the community health workers to the imminent closure of the CBO, this research looked at micro and macro issues in the organisation that could have influenced or informed their reactions. This was done using notes compiled by a colleague and myself during staff group sessions held while we were working at the CBO in 2002 as psychologists-in-training and co-facilitating a staff support group.<sup>11</sup> In addition, semi-structured interviews were conducted with three community health workers, three people in management positions, and permanent facilitator of the staff support group. In addition, the organisation's records were used to complement the data collected.

There were two significant challenges in conducting this research. The interviews were conducted in 2003, but by this time the CBO was functioning differently from the way it had been in 2002. It was now operating officially as a NPO, completely separate from the local tertiary institution that it had been part of in 2002 (the detail of the organisational structure is

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<sup>11</sup> I was working with another psychologist-in-training and a permanent facilitator (a qualified psychologist who was also responsible for our supervision).

discussed in Chapter Five). In 2003 a new board and a new project coordinator had been appointed. In addition, the intense anxiety that had characterised the mood of the CBO in 2002 had been replaced by hope for a positive future.

As a result of these changes, it was felt that there was avoidance from the staff regarding the interviews; those who took part in the research expressed reluctance to talk about 2002 and felt a need to put that experience to rest. Gobodo-Madikizela (2003) reports a similar experience while she was working with the victims of atrocities committed by the apartheid government in South Africa. She found that victims were reluctant to revisit the traumatic events. The community health workers also felt that the trauma of the previous year was part of the past and expressed a need to move on with their lives. The community health workers reaction highlights a key feature of working with trauma; discussed in chapter three which is the focus of this research, that is the difficulty inherent in revisiting trauma.

#### **4.3 Methodology**

This research uses a qualitative case study method to gather information and gain insight into the research questions posed. Stake (1995) argues that “in a qualitative case study we seek greater understanding of the case. We want to appreciate the uniqueness and complexity of its embeddedness and interaction with its contexts” (p.16). A single case study provides an opportunity to study the research question intensively (Stake, 2000; Neuman, 2003), and drawing on the experience of the community health workers at the CBO gave me an opportunity to explore the complex issues surrounding reaction to the organisation’s imminent closure. This case-study approach provided an in-depth understanding of what was being researched.

The use of a case study assisted me in defining the boundaries for the study. Gibson (2002a) argues that the research question often assists in defining the boundaries of a case study, in this instance a boundary was set by the focus being only on re-enactment of trauma in a specific community-based organisation as opposed to organisations in general. Another boundary existed in that the research was to focus only on a specific historical period in the CBO's life period, in this case the year 2002.

I have followed hermeneutic philosophy in using a qualitative method for this research. The hermeneutic paradigm regards the interpretation of meaning as central, and its emphasis is on the subjective interpretation of text and dialogue rather than on 'objective', 'factual' evidence (Kvale, 1996; Stake, 2000; Gibson, 2002a). Thus my experience and foreknowledge of the CBO prior to the data collection and analysis is perceived as an integral part of producing the results. The hermeneutic paradigm in this case is informed by intersubjectivity theory (as was outlined in Chapter Three). The use of a psychodynamic theory is important in this research because it focuses on the meaning that was created both consciously, unconsciously and intersubjectively; that is the meaning of the participants' responses, their views, and those of the researcher and how they interacted (Kvale, 1996; Hollway & Jefferson, 2002).

Citing Symon (1998), Gibson (2002a) suggests that "the strength of the case study rests on the coherence and sophistication of the theoretical framework [underpinning it] rather than any arrangement of material collection or analytic strategy" (p.87). This research relied on acquiring a deep understanding of how subjectivities of management and community health workers interacted to create the meaning of the imminent closure. The researcher's subjectivity is also part of this interaction. In addition, this research aimed to understand the way in which the

organisational systems such as communication, decision-making, and leadership lessened or exacerbated the impact of the imminent closure on the community health workers.

#### **4.3.1 Limitations of the methodology**

There are limitations inherent in the research methodology and it is important to include them when considering the outcomes of the research.

A limitation in using this methodology is that the collation and interpretation of data relies on the subjectivity and insight of the researcher. Morse (1994) says that “the researcher should enter the setting as a stranger” (p.27), but it was difficult for me to be a ‘stranger’ because I was familiar with the community health workers. I had not, however, had contact with management prior to the interviews, and my role had changed from that of a practitioner or facilitator to that of a researcher. This distancing provided an opportunity for me to see the CBO differently, and my having worked there beforehand saved time because a level of trust and rapport had already been established.

The use of intersubjectivity principles demands that as a researcher I be aware of what I bring into the study and what its impact on the research findings might be. My intersubjectivity compromised the validity and reliability of this research but paradoxically that is the strength of this research as well. In this instance, my identity as a black woman has affected my interpretation of the meaning of the data collected in this research. Another researcher using the CBO for her or his research would have found different meanings. In many instances I noticed myself identifying with the issues raised by the black staff, particularly the women; they resonated with my own experiences. The research also forced me to revisit some of the unresolved trauma in my own past and to explore its impact on my reactions to the CBO and the

community health workers. In addition, I was being trained in a psychodynamic approach, which influenced how I understood information and what I perceived as valuable and useful in the data (cf. Aron, 1999). Using intersubjectivity theory has therefore assisted me in acknowledging the impact of my own views and experiences on some of the research material, so that I could challenge my probable bias in the collecting, analysing and interpreting of the data. It is hoped that my personal insights and feelings were used positively to enhance understanding and create meaning in this research (cf. Long, 1999; Neuman, 2003; Pecego, 2003). Nonetheless, I used several sources of information; interviews, staff group session notes, and organisation's records, which allowed a triangulated methodology; an opportunity to view the data from different angles.

#### **4.4 Data collection**

As has already been mentioned, the research used different types of qualitative data, which included semi-structured interviews, the organisation's own records, and staff support group session notes. The different methods used to collect data and a description of research participants are discussed below.

##### **4.4.1 Research participants**

The research participants consisted of the five community health workers who attended the staff group sessions, the project co-ordinator in 2002, the project director, a member of the advisory board and the permanent facilitator of the staff support group. They were selected firstly on the basis that they were part of the CBO in 2002. Secondly, they were selected according to the organisational structure, to represent different views and perceptions of the difficulties facing the organisation at that time. The permanent facilitator was included because of her exposure to and experience of the CBO. (She had started working with the CBO in 1996.)

Telephonic arrangements were made with the new project co-ordinator in May 2003 and a letter requesting the consent of the organisation and staff was faxed to her (see Appendix B). This letter set out the aims and intended procedures of the research, the expected duration of interviews, and provided contact details. Approval from the staff and project coordinator was received in June 2004. A similar procedure was followed for those participants who were not based at the CBO: the previous project coordinator, the project director, one member of the board, and the permanent facilitator. The research proposal (Appendix C) was submitted to the chairperson of the new board, to gain consent for the research, which was granted.

#### **4.4.2 Interviews**

The interviews were conducted face to face, in 2004. Three community health workers out of five were interviewed. The original aims had been to include all the community health workers, but as described at the start of this chapter a number of constraints were experienced. There was also a time constraint because the interviews were conducted during my internship year and could be conducted only during working hours.

The interviews varied between 1 and 1½ hours in length and were recorded (using a tape recorder). The format of the interview varied. At the outset each participant was briefed and reminded of the objectives of the research. A semi-structured questionnaire was developed (see Appendix D). This was divided into two sections. Section A focused on the functioning of the organisation in 2002 and the way in which this had impacted on staff performance. Section B addressed the macro-level issues in 2002; the vision and objectives of the organisation, the management structure and its accessibility to staff. Including all levels of the organisation in the research was a way of ensuring the reliability of the data collected.

The themes that were included in each section are given in the table below:

Section A	Section B
<ul style="list-style-type: none"><li>– Role and responsibilities in 2002</li><li>– The functioning of the organisation in 2002 and how this affected the work</li><li>– The ways in which the CBO dealt with difficulties</li><li>– The support structure available in the organisation</li><li>– Conflict management</li></ul>	<ul style="list-style-type: none"><li>– The vision, objectives, and long-term plans of the organisation</li><li>– Strengths and weaknesses in the organisation</li><li>– The management structure and its role in the organisation</li><li>– Communication and decision-making processes</li></ul>

**4.4.3 Staff group session notes**

In 2002 my colleague and I conducted thirteen staff group sessions at the CBO, and all of them are included in this research. We wrote notes after each session, highlighting main themes, as well as noting who was present. These notes were filed at the CGC. Our reflections on and conclusions from each session were based on our experience of the group through counter-transference. The note-taking and our supervision as psychologists in training were both informed by a Kleinian model. Terminology such as projections, splitting and paranoia was used to interpret and understand the group’s fantasies and anxieties. For the purpose of this research, however, the interpretation of the data is based on intersubjectivity and self-psychology theories (as discussed in Chapter Three).

**4.4.4 The CBO’s records**

Several records kept by the CBO were used to understand its history and its aims. Access to the 2002 records was limited because they were classified as confidential by the current chairperson



of the Board and could not be viewed. Although the research focused specifically on one year (2002), I have used what seemed to me relevant information from earlier years. The sources of information and different documents that I did manage to access are described below.

- **Project progress reports for 2002:** These reports were prepared quarterly and annually by the CBO to communicate the progress of the organisation to the donor. They included budgets, spending, forecasts, goals and the outputs of the CBO.
- **Evaluation report:** In 1997 an outsider was appointed by the donor to conduct an evaluation of the CBO and to prepare a report. This evaluated the extent to which the CBO had achieved its aims and made suggestions, including a recommendation that the donor continue funding the CBO.
- **Narrative report:** This report was written in September 2002, a few months before the CBO was expected to close. An outsider was appointed by the CBO to conduct an evaluation of the organisation. It is similar to the evaluation report mentioned above, and highlighted lessons learnt as well as providing a more recent overview of the CBO.

It is important to note here that the issues that were raised in the reports above are similar to the findings of this research. The difficulty in using the records was that they had been written at a particular time and for a specific purpose, and interpreting them was not easy. Hodder (2000) refers to this type of data as 'mute evidence' because it has to be interpreted without an input from the original person or author. Interpretation is left to the user, in this case the researcher. This opens a possibility for bias because the researcher is able to select or discard information, based on what she or he perceives to be true. Hodder (2000) therefore suggests that such records should be used "alongside other forms of evidence so that the particular biases of each can be understood and compared" (p.704).

## **4.5 Data analysis**

The analysis of the data for this research began informally in 2002 while I was still working at the CBO as a psychologist-in-training. During this time I discussed the themes of the staff group sessions and prepared a presentation with colleagues at the CGC. I was therefore, familiar with some of the data before I began the analysis process that was formally undertaken for this research. I will now discuss the analysis of each type of data.

### **4.5.1 Session notes**

The thirteen sets of session notes were analysed. I reread the notes and summarised them in a table format which gave the date, attendees, and key themes of each session. After this, the main recurring and dominant themes were identified and recorded.

### **4.5.2 Interviews**

I employed a post-graduate student in the Faculty of Arts at UCT to assist me in transcribing the interviews. Before any work was undertaken the student agreed to a confidentiality undertaking. A format for capturing the interviews was decided upon and discussed before and after the transcription to ensure that information was not omitted. I also listened to the tapes after they had been transcribed and made corrections. Citing Potter & Wetherall (1987), Douglas (2000) argues that this process allows the researcher to be submerged in the data.

Each interview was analysed separately and themes were identified within each interview. All the themes, together with the names of interviewees, were put in table format and later on overall themes were identified. Two tables were created: one for management and one for the community health workers. Initially I wanted to present the themes from each group (management and staff)

separately but I later realised that there were significant similarities in their themes. As a result, the themes were combined, but any significant differences in responses or views have been noted.

Direct quotations from the responses were used to support the results (see Chapter Five). This process was characterised by a lot of self-interrogation and examination of the data to identify what was relevant and significant. Morse (1994) suggests that data analysis is “a process ... of piecing together data, of making the invisible obvious, recognising the significant from the insignificant” (p.25). She describes it as “a creative process of organising data so that the analytic scheme will appear obvious” (ibid.). This is what I was hoping to achieve.

#### **4.5.3 The CBO's records**

I read all the records that were received from the CBO in order to identify important information, thereafter the documents that I considered to be irrelevant or repetitive were omitted. For instance only a few of the quarterly reports were used to elicit the purpose of the CBO and its goals. However the evaluation reports were found to be very useful because they were detailed, and discussed the aims, strengths and weaknesses of the CBO. This information is used in Chapter Five to describe the case study and to confirm interview data.

#### **4.6 Ethical considerations**

Consent from the Board of the CBO was received to conduct interviews and to make use of organisation's records. Each interviewee also gave their consent to be interviewed. Permission to use the session notes was, however, not directly attained. That is, I did not formally request permission from the staff support group members to use the session notes for this research. The reason for this omission was that, as part of its practice, the CGC requires that every client sign a consent form which gives the clinic permission to use the clinical material for training and/or

research. The group session notes fell under this agreement. In addition, participants were informed at the outset that the research would be based on the experience I had gained while working with the staff support group at the CBO.

I have tried to protect the identity of the participants but I am concerned that what I have done might not be enough. Although the confidentiality of participants was maintained (see Neuman, 2003), the organisation used for this research is very small and this may make it easier to identify the participants and their responses. The sharing of this information thus poses an ethical issue. Maw (1996) and Long (1999) highlighted similar concerns in their research. Both authors were concerned about the people they were describing and about their own power as researchers, because power dynamics are replayed in the production of knowledge and in determining what is the 'truth' is in the research material (ibid.).

Maw (1996) and Long (1999) both emphasise that there is nevertheless a need for this kind of research, particularly in developing community psychology praxis in South Africa. Long (1999) argues: "The ethical problems of writing about my interaction with people I came to know and respect are outweighed by the ethical problem of not writing about issues which are central to progressive psychology in South Africa at this time" (p.4). I agree with these authors. Nonetheless, it was difficult at times to open wounds and probe into personal issues for research rather than for therapeutic purpose. This made me question whether the research was for the benefit of the organisation or simply for my own training. At this stage the latter is certain; with regard to the former, I have made an informal contract to feed back the results of my study to the organisation.

#### **4.7 Summary**

This chapter outlined the methodology of this research. A qualitative case study approach was deemed most suitable in enabling me to explore the reactions of the community health workers at the CBO to the imminent closure. Drawing from different sources of data; interviews, staff group sessions notes, and organisation documents, provided a triangulated paradigm and strengthened the results of this research. The next chapter provides a description of the case study and a summary of the results.

University of Cape Town

## **CHAPTER FIVE**

### **CASE HISTORY**

#### **5.1 Introduction**

This chapter sets the scene for the main discussion that follows in Chapter Six. I begin by describing the history of the community-based organisation (CBO) where I did the research, its location, organisational structure and client profile. The second section describes the staff support group and organisational dynamics, and the relationship between the CBO, the Child Guidance Clinic (CGC) and the staff support group members. In the last section I describe the first support group session, to give the reader a sense of the group process and of how the group presented itself to us as facilitators. Thereafter I present the key themes from the group sessions, the semi structured interviews, and the organisation's records.

#### **5.2 History of the CBO**

The CBO was established in 1993 in response to child mental health epidemiological research undertaken by a department at the local tertiary institution. The research was community-based and showed that "around a quarter of households in Khayelitsha needed psychosocial services for children, adolescents and families" (CBO Evaluation Report, 1997, p.24).

There was also an urgent request from the health committees in the community to provide health services. The research concluded that:

Two things were very clear. Firstly, people in [the community] were severely underserved in many areas, but virtually completely unserved in the area of mental health. Secondly, hoping that the problem could or would be solved by an expansion of the highly professional model enjoyed by the wealthiest (white) portion of the population was not feasible, and perhaps also not desirable (CBO Evaluation Report, 1997, p.24).

The CBO described in this thesis was started with financial assistance from local and overseas donors. It was based on the layperson model<sup>12</sup> developed specifically around counselling, with the assistance of only a few part-time professionals.

A primary objective of the CBO was to employ their community health workers, not as a second or third option driven by affordability, but rather as a *means of empowering the community* by providing the people living in an area with skills that would make them more self-reliant. The health workers were engaged by the CBO to focus on prevention of mental illness and on the promotion of health, rather than simply on curing existing problems. In this respect the objectives of the CBO were in line with the general direction of the progressive primary health care thrust of the new South African government and the World Health Organisation (WHO). The CBO was developing a new model in focusing on mental health, but it drew on other initiatives such as the community health worker models of other NGO projects in the Western Cape, elsewhere in South Africa and beyond. A summary of past (1994-1997) and future (1998-2001) objectives of the CBO is provided in the table below, as outlined in the CBO's 1997 Evaluation Report.

<p><b>1994 – 1997</b></p> <ul style="list-style-type: none"><li>• To develop a model for providing accessible and affordable assistance to children and adolescents and their families in crisis in Khayelitsha,</li><li>• To train members of the community to provide this assistance,</li><li>• To develop screening methods through which ‘at risk’ children and adolescents could be identified and to transfer these skills to key community members such as teachers,</li><li>• To establish groups to address specific presenting problems, and also to prevent future problems and promote mental health in children and adolescents and their families.</li></ul>
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<sup>12</sup> The laypeople in this case being the ‘community health workers’ i.e. health workers drawn from the local community.

#### **1998 – 2001**

- To continue to intervene with children, adolescents and their families who present with emotional, behavioural and relationship difficulties,
- To develop community capacity to assist children and adolescents in crisis (skills training of key people working with children in the community, community workshops, media programmes),
- To lobby for children's issues at local and provincial government levels, and to facilitate community lobbying,
- To evaluate the effectiveness of community-based strategies for minimising the impact of risk factors in child functioning and development and to compare this with individual interventions.

According to the CBO's 2002 Evaluation Report, the organisation had plans to replace the current organisation with an independent Non-Profit Organisation (NPO) separate from the local tertiary institution, while maintaining some "personal and contractual relationships" with the local tertiary institution. This has subsequently happened and the CBO is operating as an NPO and has appointed new management, which includes a board and a full-time director (rather than a coordinator).

#### **5.3 Location of the CBO**

The CBO was located on the premises of the local tertiary institution's community project. One of the many problems resulting from having to share premises with another organisation was that the community health workers could not guarantee being able to provide a safe space for the children with whom they worked. Their work facilities were extremely basic when compared with my office at UCT, which was carpeted and freshly painted, with a phone, computer and printer. At the project site there was a small bungalow outside the main building, with one window. Although only two of the community health workers were supposed to share the



bungalow, most of the time we would find all the workers inside, sitting and chatting with each other. On a few occasions, especially in winter, we would all huddle into the bungalow around a small gas heater. In the main building, which was shared with another health organisation, the space allocation was not very clear. The six community health workers shared one phone. Most of the time the photocopy machine did not seem to work and receiving faxes was difficult. At some point the phone was disconnected because there was a large outstanding account.

Despite all these difficulties and constraints, we were always greeted with a smile and a laugh. I was amazed by the capacity of the workers to laugh, joke and tease, and one would not have imagined that some of them had been working under these conditions for 10 to 12 years.

**5.4 Organisational structure of the CBO and lines of authority**

The organogram (Figure 5.1) shown below reflects the structure of the CBO, and shows roles and responsibilities.

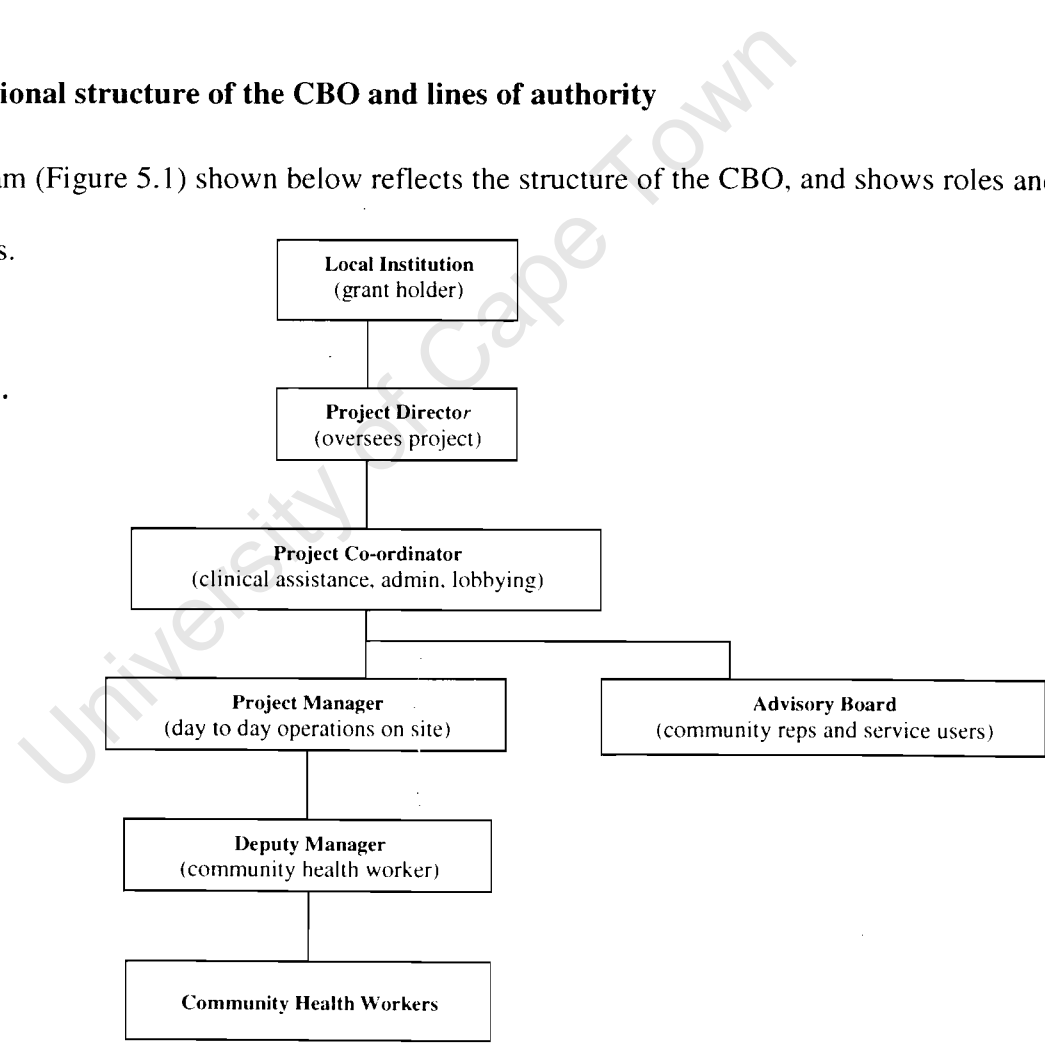


Figure 5.1 Structure of the CBO in 2002

As can be seen, the structure was linear, with few career opportunities, particularly for the community health workers. Although the structure appears clear, ownership of authority and delegation of responsibilities were not very clear. I discuss this issue in detail later in this chapter, however, it is important to note that the position of the advisory board was relatively far down in the hierarchy and it therefore reported to the project co-ordinator. The role of the advisory board was not very clear; it did not have any formal decision-making power or authority. Its identity was also not clear because it was referred to by different names, each of which implied a different role. For example it was known as the advisory committee, the advisory board or the steering committee.

The local tertiary institution provided both overall leadership and management of the organisation, including raising and managing its funds. It formally employed the CBO health workers, and their salaries and benefits were set according to the grading system of the institution. It also used the services of other clinical and medical professionals, including a psychologist who provided clinical supervision to some of the community health workers.

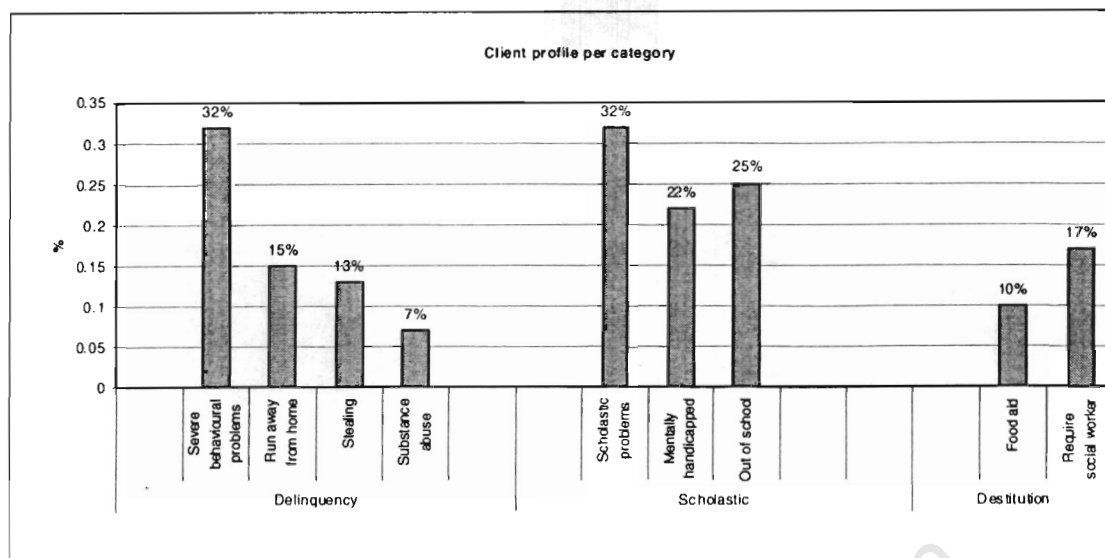
The CBO advisory board was comprised of community representatives and service users and members of the tertiary institution. The CBO had one part-time psychologist who was appointed as the Project Co-ordinator, who was responsible for the administration, management of the projects (on site) as well as lobbying. The Project Co-ordinator also provided clinical assistance and, together with the Project Manager, was a member of the management committee and of the Board.

## 5.5 Client profile of the CBO

Children who were traumatised and rarely received help, because primary care givers did not recognise their symptoms, characterised the client profile of the CBO. Some of these children were neglected because their parents had to go out to work, or to seek work. The CBO approached schools and used media programmes and workshops to raise awareness and reach children and their families. Children were also referred to the CBO by other local non-governmental organisations.

The majority of the children were diagnosed with severe depression and anxiety disorders. According to the documents which the organisation prepared for funding applications, the clients could be divided into three main categories: delinquency, scholastic difficulties including mental handicap, and destitution. The graph shown on the next page (Figure 5.2) reflects the percentages of children falling into each of these categories. A client can fall in more than one category, hence the percentages sum to more than 100%. There were also children who came from rural areas who were having difficulty adjusting to urban life and separation from their caretakers. These children had been exposed to a different quality of schooling and were at risk of developing behavioural problems and depression.

Some of the children seen at the CBO had also been sexually abused. According to the community health workers, since its inception ten years before, the CBO had provided service to approximately 16 000 people and had received referrals from several professional NGOs and schools. They had also been identified by these organisations as a valuable community resource and often the only recourse for some people.



Source: CBO documents

Figure 5.2

## 5.6 Relationship between the CBO and the Child Guidance Clinic

The initial Project Coordinator at the CBO had been a student at the CGC and had recently qualified as a clinical psychologist. The relationship between the CBO and the Child Guidance Clinic (CGC) at the University of Cape Town began in 1996 when the Project Coordinator approached the CGC requesting assistance in meeting the community health workers' training needs and to support them in dealing with stress and burnout<sup>13</sup>. Subsequently, a contract was drawn up between the Project Coordinator and the CGC to conduct a staff support group. The community health workers indicated during their interviews in 2003 that there had been little consultation with them about setting up this group.

<sup>13</sup> From CGC client's session notes.

5.7 The staff support group

5.7.1 Profile of staff group members

The staff group was comprised of five community health workers except the Project Co-ordinator (Jenny<sup>14</sup>). From the beginning of 2002 the Project Manager (Shireen) decided to exclude herself from the support group. She informed the staff that she did not need to attend the group sessions because she was receiving direct supervision from the permanent facilitator (Pam). The community health workers involved were Nosenzo, Sandise, Joyce, Musa and Nomsa. The CGC team consisted of a permanent facilitator/psychologist and two psychologists-in-training whom she supervised, and who acted as co-facilitators.

Staff	Description
Sandise	Sandise started at the CBO in 1995. She was married with 3 children and living with a younger relative. <sup>15</sup> Because she was due to start facilitating a new project in mid-2002, her position was not threatened by probable retrenchment.
Joyce	Joyce had been working for the CBO for over ten years. She was a single mother with 2 children. Prior to working at the CBO she had had her own business.
Nomsa	Nomsa had also been working for the CBO for over ten years. She was single mother with 3 children. She stayed with her two brothers who were not supportive, one of whom had 3 children.
Nosenzo	Nosenzo had started off as a community researcher and had also been with the CBO for a decade. She was married with 5 children. She was the main breadwinner since her husband was unemployed. Her eldest daughter was studying at one of the local universities.

<sup>14</sup> For anonymity, names have been changed throughout.

<sup>15</sup> Details regarding marital status and number of children have been included to highlight the significant personal responsibilities that these staff members faced.

<b>Musa</b>	Musa was the youngest in the group and the only man. He had been with the CBO for six years, starting as a volunteer. He had recently married and had a young child. He described himself as a traditional man and as the ‘head of [the] family’.
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Since the brief for the CGC changed every year, our first aim in 2002 was to identify the needs of the group for that year. In previous years the intervention had included skills training which had been identified as a need by the CGC and the community health workers. However it was clear from the beginning that our intervention in 2002 would need to be flexible because the group seemed greatly affected by the impending closure of the organisation, and most of their energy was focused on this.

The staff support group sessions took place every second week, at the project site in Khayelitsha and lasted for an hour. During these sessions there was little mention by the community health workers of their clients or of cases they were working on. They were preoccupied with the imminent closure of CBO and its consequences for them.

It is important to note that there were few or no sessions in which all of the members were present. Even though the dates for the meeting were communicated well in advance, it seemed that every time we arrived the members were not ready to see us. The meetings took a long time to get started and we were never sure what was going to happen. Even though there was anxiety on our side and reluctance from the groups’ side about whether or not we would have the meetings, when this issue was raised, the group members insisted that we continue.

### 5.7.2 Staff group members and organisation dynamics

There were two main sub-groups, as shown in Figure 5.3<sup>16</sup> on the next page.

<sup>16</sup> Source: Academic presentation at CGC by Nontsikelelo Ndumela and Hayley Julius, 2001.

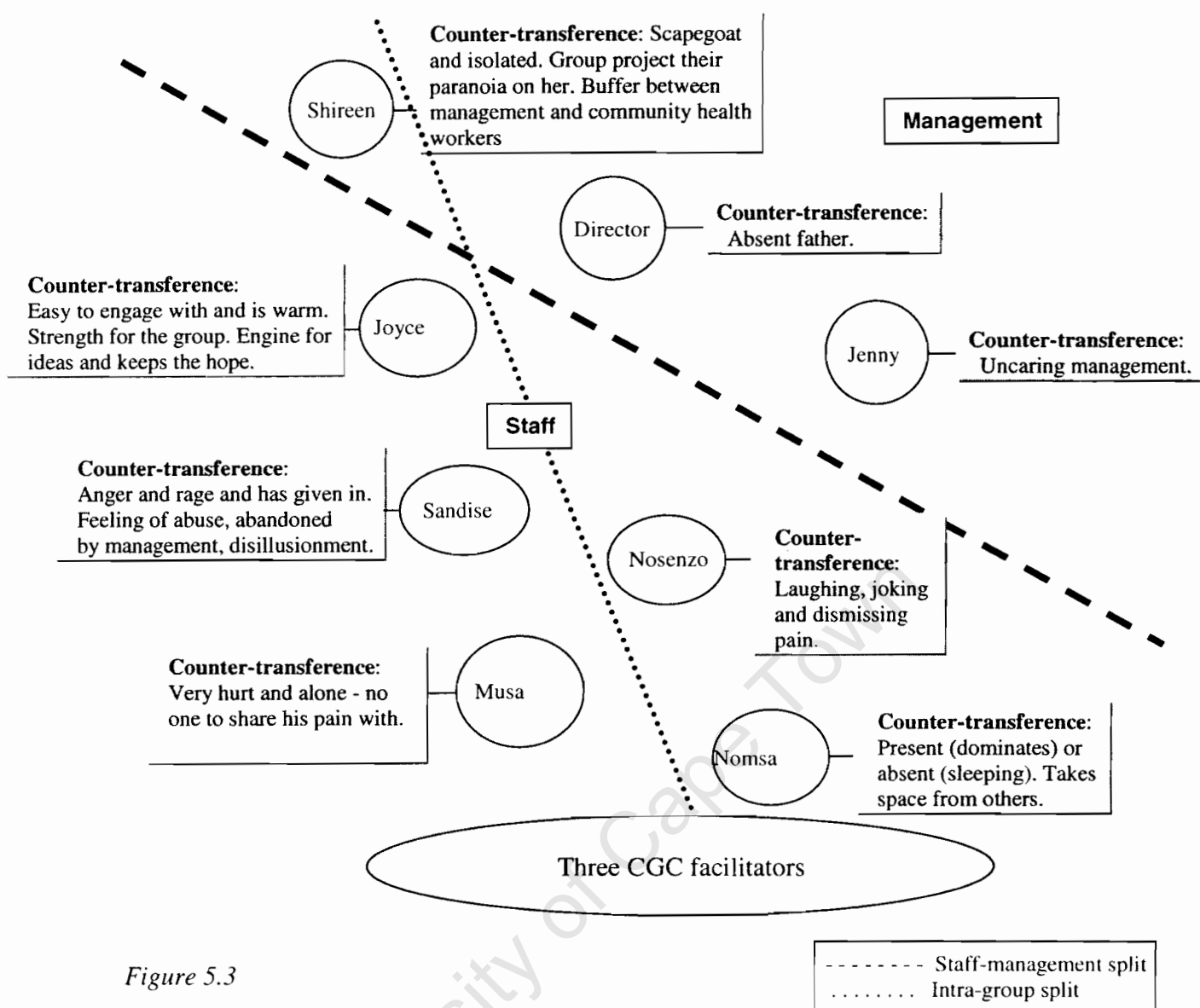


Figure 5.3

The primary divide was between the community health workers who attended the support group on the one hand, and management (both at the CBO and at the local tertiary institution) on the other. This division was overt and the staff group referred to it many times. Group members said that management was trying to provide information about their future in the organisation but that they were not happy with the process. It seemed that although management was attempting to lessen the effects of trauma, their actions were in fact re-traumatising the group members. We

(the CGC facilitators) had positioned ourselves in the organisation on the side of the community health workers. Although the CGC had initially been brought in by the project co-ordinator (as mentioned above), in 2002 the facilitators did not have contact with management and this seemed to maintain the split in the organisation.

The second split was within the health workers' group, where subgroups became visible as the sessions progressed. The first subgroup consisted of Sandise, Joyce, and Musa, who gave each other support and were clearer about finding alternative employment. Nomsa and Nosenzo each appeared to be standing on their own. The group underplayed the intra-group split in order to emphasise both intra-group cohesion and the division between the community health workers and management.

The counter-transference (see Chapter Three) shown in this diagram reflects the facilitators' experience of the community health workers, and the way in which the facilitators experienced management through the community health workers.

### **5.7.3 The staff support group process from April to November 2002**

My placement as a psychologist-in-training at the CBO was from April until November 2002, and in total we had thirteen staff support group sessions. On our way to the first session with the staff group, the permanent facilitator gave us (psychologists-in-training) feedback from her visit the week before<sup>17</sup>. She told us that when she had first arrived at the CBO in 1996, the community health workers had not been expecting her, and that she had not known what to do with the group, being unsure whether to concentrate on skills development or mainly provide a containing space for the group. It seemed to us that her uncertainty was similar to those of the group

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<sup>17</sup> The permanent facilitator continued to see the group between university academic terms and during holidays, to maintain continuity with the staff group.



members. She said that in the past the group had tended to request structured activities when things were not under control in the organisation. The effect of this conversation upon us as facilitators was that it left us with similar feelings of anxiety because there was a lack of structure.

When we arrived at the CBO, Nosenzo came out to greet us and told us, as we went into the session room, that she would be excusing herself at 11 o'clock. She explained that she had to go and collect children for a group of her own, which she was now in the process of terminating, to allow her to participate in and benefit from our group sessions. She seemed pleased by this. All the group members were present in the first group session except Nomsa and the project manager.

The group started with introductions; everyone stated where they 'originally' came from (birth place), gave their clan names, work experience, marital status, and number of children. This seems to follow the tradition of the community itself because most of the people who live in Khayelitsha originally come from the Eastern Cape, even though they might have been living in the Western Cape for many years. The Eastern Cape is regarded as home and Khayelitsha as a temporary place.

Joyce admitted that she tended to forget the psychologists-in-training after they left and mentioned that recently she had bumped into one of them but had not remembered her, and that she saw another on television but had not at first realised that she knew him. The permanent facilitator said that there had been eight psychologists-in-training who had worked on the project although the group agreed with this they seemed unsure about how many psychologists-in-training had worked with the group. I thought that the group might be feeling used merely as a

vehicle for the training of students and that they would be ambivalent about forming a relationship with the psychologists-in-training. I was also feeling ambivalent about my own placement, which I had discussed with CGC staff. On the one hand, I was questioning whether I had been placed at the CBO because I was a black female and the project was based in a township and staffed mainly by black women. On the other hand I saw this as an opportunity to use my organisational and development skills within a psychodynamic approach.

At first the group was reluctant to talk about their problems in the organisation and focused instead on the new psychologists-in-training. They also discussed outside issues such as the powerlessness of the community in the face of HIV/Aids and the community's lack of education and awareness. When the permanent facilitator (Pam) asked how the group felt about the organisation, group members became uncomfortable and announced that they would prefer not to talk about the CBO. Nosenzo stood up and announced that she was going to make herself tea as she was leaving soon to collect her group. She sat outside the circle while drinking her tea and left immediately afterwards. It seemed that Pam's question had disturbed the group and raised their anxiety about the organisation. I also understood their reaction as one of fear, but was uncertain as to who or what the source of fear was. Joyce then started to talk and began to clarify the community health workers' hesitation and reluctance. She kept stopping herself as she spoke and said, "I do not want to talk about this" (referring to the CBO).

The group members said that they had not been given any notification about proposed changes at the CBO, but confirmed that there was uncertainty about its future, and it seemed that rumours were the source of their information. Despite their reluctance to discuss the CBO's future, it was clear that the group members had strong feelings about the imminent closure of the organisation. Joyce said, "There will be a fight one day because of the existing conflict in the organisation," in

this way expressing her anger and frustration. Even though it was not clear who would be fighting with whom, there was a definite feeling of 'us and them' between management and health workers. The group expressed its distrust of management and of how the funds of the organisation were being used; management was seen as cashing a lot of money, and as being dishonest about the organisation's financial position.

The reasons for firing Aubrey (a previous employee) were also questioned. The group believed that it had been because he had asked questions and that the management had felt uncomfortable about this and therefore fired him. Group members said that the management was using Aubrey's salary to fund other initiatives; they saw this as meaning that there was money and that management was not being honest with them.

The group also said that, because they were more expensive, the management was trying to replace them with volunteers whom they would be expected to train. They said that they had been told that most of the organisation's funds went to their salaries. It seemed to me that the group members did not understand the role of the volunteers and felt threatened by them. In addition they said that they had not found time to think about or 'digest' the imminent closure of the organisation because there were so many cases to attend to at the CBO. They said that it was only when they got home that they started to think about this issue.

As can be seen from the above, the first session was dominated by anger, distrust and paranoia. The fragmentation and disintegration in the organisation, and the dissatisfaction with management, particularly with Shireen had begun to show. In the next section I have summarised the common themes from all the sessions in 2002.

## 5.8 Thematic analysis

The opinions voiced in the group sessions in 2002 and the interviews held in 2003 have been grouped into themes. These are outlined in the following section.

### 5.8.1 Themes from staff support group sessions

The staff group sessions throughout 2002 had recurring themes that encapsulated the feelings of the community health workers towards the organisation and its imminent closure. A summary of each group session is outlined in Appendix A. However, it is important to highlight the overall themes that arose from these sessions:

- i) **Ambivalence:** The group members were anxious about their imminent loss of income, which could also result in the loss of their status in the community. Most of them were also breadwinners with a number of dependants and responsibilities, and like their clients, came from traumatised and difficult backgrounds. The group was, however, ambivalent about having to take action to find alternative employment, the clients, receiving nurturance, and about the group sessions.
- ii) **Anger with management and feelings of betrayal:** The group members felt abused and injured by management. For example, in session six the community health workers stated “we need bandages and panados”; and that management was abusing them because “[they] are kaffirs<sup>18</sup> with short hair”.
- iii) **Distrust of management:** The management of funds by management was frequently questioned in the sessions because there was no funding available to continue the CBO. The group members felt that management had misused or hidden the money and was holding back on information.

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<sup>18</sup> A derogatory and highly offensive term used mainly by white South Africans to refer to black people.

- iv) **Dependency and vulnerable feelings:** The health workers were experiencing severe stress due to the changes in the organisation. There was a sense of powerlessness and helplessness. Group members had a poor and fragile sense of themselves and difficulty in recognising their own value and self-worth.

### **5.8.2 Themes from the semi-structured interviews**

There were significant similarities in the issues raised in the interviews by both the management and the community health workers, indicating a level of agreement about the difficulties and problems faced by the CBO in 2002. The themes discussed below therefore reflect the views of both the leadership/management of the CBO and the community health workers. I have highlighted those areas where there was disagreement or a difference in the opinion.

#### **5.8.2.1 Dysfunctional patterns in the organisation's systems**

It was felt that the way the CBO was initially set up had caused difficulties in terms of managing and overseeing the CBO. The organisation ran on part-time management and only the 'staff on the ground' (community health workers) were full-time. In addition the CBO was one of many projects run by the local tertiary institution and this is reflected in the following response:

**Management response:** One other mistake is that when [X] came on as a project coordinator the [CBO] was viewed as part of his job. His other responsibilities were to coordinate all [the project's director's] research projects, and increasingly the CBO became a full time position [for him]. So if the project coordinator position was a fulltime from the start, had it been located in Khayelitsha, it would have been easier because there was always a sense of remoteness in dealing with [the local tertiary institution] ... which is huge and [bureaucratic].

The CBO could not develop a clear identity because it was geographically separate from the tertiary institution, and the community health workers described themselves as employees of the

CBO rather than of the tertiary institution. This suggests that they perceived the CBO as their employer even though its administration and management were located at the tertiary institution. It also highlights the shortcomings of the local tertiary institution in playing its 'parental role' effectively.

The imminent closure of the CBO in 2002 revealed deficiencies in core organisational systems and procedures which had been there since the CBOs inception and had never been resolved. During this period it became clear that it was operating informally and that most procedures were not clarified or communicated, even to management, let alone to the community health workers. As a result, the imminent closure brought confusion, and a lot of pain and insecurity for staff<sup>19</sup>. The depth of the trauma of 2002 is captured by the following:

**Management response:** The trauma of last year [was] a trauma of a near death experience. It was desperate, fighting for survival. The relationships were broken down and this caused the trauma and fight for survival. Staff became paranoid about each other.

Three key areas were highlighted regarding the way in which the CBO was managed. Firstly, communication processes were ineffective in meeting the needs of the community health workers. The health workers described the communication process as poor, fragmented, and didactic. In addition, the information shared with them was regarded as inconsistent and changing all the time, creating a lot of confusion and more paranoia. The health workers felt that communications from management were deliberately designed to confuse them and when they asked questions management personalised the questions, rather than understanding the general underlying anxiety of all the community health workers.

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<sup>19</sup> In this section (interviews), the word 'staff' refers to both community health workers and management.

Secondly, the budgeting process came under scrutiny. The health workers' responses indicated that the organisation's processes of budgeting and spending money were not clear. The community health workers' information on available funds was inconsistent and seemed to have been received informally. Their responses indicated a level of suspicion regarding the way money was handled at the CBO. Here are some examples:

**Community health worker's response:** We were informed by the donor assessor that we had saved R800 000 and there was also R200 000, which makes a million, and we could run for another three years. We do not know what happened to that money, and [management] did not want to answer our questions.

**Management response:** The staff's worry [about] white people chowing the money was expressed to me and something did not make sense to me as well. ... I do not understand it myself. How money was used was not clear.

The third criticism was that, historically, roles, promotions, and performance management within the organisation was not clarified. The community health workers said that roles were not clearly defined, especially at management level: "People get promoted and we are not informed and you do not know how they got promoted." In addition, the constant changes in management, for instance the appointment of the project coordinator in 2002, were not well communicated or managed at the CBO.

**Management response:** [X] resigned at the beginning of June 2001 and left at the end of June, and asked me to take over and I said yes. I was leaving to go to a conference. He literally asked me as I was leaving to get on the plane. I was gone for three weeks. When I came back there were only three days left, so the staff did not have any time to think about it, talk it over and get to know me in that new capacity. ... The project director was on sabbatical at the time so he was really not around. I am not sure how my input into the programme was negotiated but I have a sense it never went down well with the staff ... It has been a rocky road but I have managed to gain their trust.

Although this way of managing an organisation could provide flexibility for management, it seems to have created uncertainty for the community health workers: One of them responded by saying, “Changes at management level are unbearable.”

None of the job descriptions were regularly updated and appointments were conducted informally. Rewarding the health workers for good performance was also conducted informally, creating splits and suspicions amongst the health workers themselves, as indicated in the following response:

**Community health worker’s response:** People would think that you are promoted because the white person [management] likes you. Then [the other health workers] wonder why you are being treated as a ‘special’ person. They think the white person likes you because you are betraying them.

In 2002 the management’s strategy for finding ways to raise funds and ‘save’ the organisation exacerbated the split and lack of cohesion in the organisation. For instance, certain individual’s projects were identified for fund raising, while others were not. Plans were made to raise funds for these projects, such as HIV/Aids, which meant that those responsible for such projects did not face the threat of retrenchment. This strategy was described by a member of management as creating “a lot of envy amongst staff, and deep unhappiness”. The health workers started to have questions such as “Are you better than me?”, “Why is your project getting funding and not mine?” and “Why is your survival important and I could be thrown or expendable?”

It seems that in 2002 the management of the CBO was struggling to cope with the impending changes, and with understanding the extent of the anxiety being experienced by staff members. The lack of formal procedures created confusion and a lack of transparency.



#### **5.8.2.2 Authority, power and leadership**

According to Obholzer (1994) clear lines of authority, sharing of power and leadership are very important elements for the well functioning of an organisation. The leadership style at the CBO was described as authoritarian and controlling. Leadership was located at the tertiary institution and was not involved at the CBO most of the time, it was described, again by all the staff, as being “present without being present” at the CBO, which made decision-making difficult. Responses from the interviews indicated that decisions had been blocked or deferred.

Furthermore, the imbalance of power and authority creates dysfunction in an organisation, for example, at the CBO authority without power made it difficult for middle management to own their roles and function effectively. Decision-making powers were not delegated to the board or to middle management. This lack of capacity was more visible in 2002 and at times of crisis. The incident described in the following interchange illustrates this.

**Management response:** One of the big problems dynamically was the geographical separation between the local tertiary institution and Khayelitsha. That functioned in two ways, one is, I was very remote from the staff; there was no office space for me (at the project site). It meant that they felt that they did not have access to me.

In a way I was remote ... because things will happen and I will not know about them. For example, something that frightened me as much as them: a youth came to the door [at the CBO] and said [to the community health workers], “I have a gun, I’m gonna shoot you.” I was here [at the local institution] and they were in Khayelitsha. They [Shireen] phoned the office and I was not here, they left a message on my cellphone and I was in meetings so my cellphone was off. And two hours later I get a message that says, ‘What must we do?’

To me that incident encapsulates a couple of things, not only that the environment in Khayelitsha is sometimes very frightening to work in. Shireen needed to take leadership – [she] needed to decide whether to close the project or phone the police.

**Interviewer:** Do you think that that she was aware or clear that she had these decision-making powers?

**Management response:** She should be – I told her on a number of occasions ... She should and could have made the decision.

It is important to note that despite the interviewee's opinion that the project manager should have been aware of her own decision-making power, other responses indicated that the procedures at the CBO were informal and roles were not clearly defined. Therefore it would have been difficult for the project manager to have been certain of the correct course of action, particularly in such a traumatic situation. In addition, it is not clear whether the project manager had received any formal training in her new role. Here is an opinion of one of the management interviewees:

**Management response:** The role of [the project manager] was never clear and she seems to have trouble functioning.

**Management response:** They are highly skilled mental health workers but not given organisational skills. The management positions and decision-making has remained in the coordinator role, which is always a white person and always a psychologist or professionals. It is rooted in this country, [the local tertiary institution] started this project and shows it to the world but ... never thought through how [it] was going to be sustained.

**Management response:** The role of the board was never clear and it struggled with an identity crisis for four to five years. It struggled to own because it did not have authority to own itself. It did not have any capacity to make decisions and take things forward ... You get told that there is a meeting but you do not have much to say because it gets blocked.

The local tertiary institution had given responsibilities to management without giving them any clear authority to make decisions, which disempowered middle management and created insecurity for the community health workers. One of the staff said "the role of middle

management was to run the project smooth.” In this case ‘smooth’ meant suppressing any disagreement with management.

According to the interview responses, at the beginning of the project the leadership at the CBO was directly involved but later they withdrew. This leadership was shifted to the project coordinator position, but there have been many resignations and changes at this level so it has been difficult for the organisation to have a vision. This is reflected in the following interview response:

**Management response:** Until we [the local tertiary institution] decided to separate [the CBO] we at had not thought about the future. In my vision what I had in mind was that the community would run the operation, I had not really thought that far ahead or thought about being financially responsible for it. When we started in 1993 or 94 ... I do not think I even thought that it might be possible for a community organisation to actually fundraise and become sustainable, because I was thinking in terms of people like community workers who had no formal training. We wanted them to be like so that they could be identified by the community as being similar to them. We did not want them to be distant. I was not thinking in those terms, that these people might take over the organisation; it did not occur to me.

The idea was that it was going to be run by people from Khayelitsha, that was one of the agreements (with civic organisations) ... I think you can certainly say that I was naïve. I can accept that in terms of not being aware of all these complexities and ... here I was responding to a need. I cannot see how one could have done differently, you cannot hand over money to people; you have to train them first ...

A lack of vision hindered the organisation from growing and adapting to the changing environment it was operating in. Since roles were not clearly defined it became difficult for individuals who had been assigned leadership responsibilities to perform and take ownership of their roles. This resulted in conflict and in leaders blaming each other for poor performance or

lack of decision-making. The interview results indicate that leadership of the CBO was not only physically absent but also symbolically.

### **5.8.2.3 Race and trust**

Some of the complexities of race and trust in South Africa have been described in Chapter Three. It seems that this pattern of distrust and paranoia between races was being repeated within the CBO. The following responses indicate this:

**Management response:** I was trusted to make decisions because I was white.

**Community health worker's response:** [X] told us that you can study anything you want, but you are not going to be management. As a result, we have lots of certificates but they are just sitting here and we have no experience.

**Community health worker's response:** Our organisation has remained white even though we wanted a black person. One day I asked, "Why don't you give us a chance to do this on our own without white people?" We wanted a black person to be the new director but we were told that the one they interviewed was weak.

**Community health worker's response:** I have a problem with white people who come here and develop themselves, go overseas, while we remain here. I have an attitude towards white people [because] they will bring something [skills] but will not share everything. I have no problem with you [interviewer] because we black people are underdeveloped and I want you to pass your thesis very well.

These responses reflected the perceptions amongst the CBO staff about black and white people. Distrust and lack of understanding is also reflected in the way money was treated in the organisation:

**Management response:** If I look at some statements made and implications ... it was not overtly said but there was always a worry that the outside people [advisory board members] want to get their hands on the money. The staff's worry about white people chowing the money was expressed ... Let's face it, it's about money. White people

on the board say, “We would hold on to this money”... The fear of letting go, not only of authority but fear of having that money exposed to people. The distrust that exists with racism, and the distrust that exists with people in the community: “[They] will exploit the money if they get their hands on it, [that is] the street committee or corrupt people and the money will disappear.”

The crisis that the organisation was facing thus brought out not only the personal trauma experienced by each staff member, but also re-enacted socio-political traumas that had not been adequately addressed in the past. It replayed the social and political dynamics that are evident in broader society.

#### ***5.8.2.4 The therapists’ understanding of the role of the psychologist at the CBO***

The results of this research indicate that the application of a psychodynamic framework to the staff support group at the CBO was more useful rather than a ‘pure’ psychoanalytic approach. This is reflected in the following statements that were taken from the interview with the permanent facilitator of the staff group who had been working with the CBO for approximately six years. She summarised her learning and key issues as follows:

- i) The classical definition of boundaries in a therapeutic group was challenged. It was difficult to maintain strict boundaries in terms of time, the content of the sessions and the presence of the participants. The members of the group came and went because their clients were waiting. Therefore the issue was not about breaking or not breaking the boundaries but about *being mindful* of the significance of this.
- ii) It was difficult for the therapists to remain neutral and not share a lot about themselves. There was a level of sharing of information, and the psychologists-in-training sometimes shared something about themselves.

- iii) Conducting group sessions fortnightly and for one hour each time had an impact on trust, as well as on the structure of the sessions. It was difficult to develop trust and hard to know what to talk about after a two week gap because so many things had happened in the interim.
- iv) Doing therapy requires incredible patience, one has to watch a person or group doing something that seems to not be good for them, and to contain the temptation to interfere in order to make things better.
- v) Race, gender, and class are highly salient in this context, however it was difficult for the community health workers to acknowledge these factors and down played their impact. By way of an example the permanent facilitator gave the following account:

[At one time there was a] bus boycott and the [CGC staff] missed two or three sessions. When we tried to talk about what they felt about that because we were privileged people and had decided we were not going to come because it was not safe, whereas they have to live there all the time. They would not acknowledge it and they just said, "We understand; we do not want you to be in danger." Maybe they were right, they were not angry but it was impossible to talk about it.

- vi) There was a strong temptation to make things better for the community health workers because their lives are very traumatic. It was hard to sit with these difficult feelings.

The permanent facilitator stated that in 2002 the organisation was hardly functioning and was struggling to deal with an abrupt closure. She felt that the difficulties had been around for years, but the community health workers had found it difficult to talk about them. She added that in the therapeutic setting the community health workers were also struggling to hear the feedback about the cause of their difficulties. As a result, it was difficult for the psychologists to confront the behaviour of the community health workers without risking the retraumatising them:

**Permanent facilitator's response:** when a patient is in an acute state, there is nothing you can do except to hold [contain them].

Support structures such as supervisions and staff support groups that had worked in the past were also affected. The community health workers' emotions seemed to spill over and were uncontained during this period, as is indicated by these responses:

**Management response:** [The CBO] did not just need a staff [support] group but something to make the meaning of the larger process. The fundamental flaw was to exclude the middle management, maintaining the split in the organisation.

**Management response:** The staff group was not enough they also needed perspective. You cannot just create a group for people to offload and share in the midst where they are not cohesive. The cohesiveness of the group was lost. People were now against each other. [As a result] the staff group was set up for failure.

These responses highlight the trauma that the community health workers were experiencing, and the difficulties in applying a traditional psychoanalytic model in a community-based setting. The question is raised of whether the staff group intervention was adequate or whether the CGC team could have adapted their approach to assist the community health workers and the organisation in dealing with the imminent closure differently.

## **5.9 The evaluation and narrative reports (CBO's records)**

The information from the CBO's records has been grouped into main themes, and these are outlined in the following section.

### **5.9.1 Evaluation Report (1997)**

As explained earlier, this report was written for the CBO's funders. It focused mainly on critical areas and weaknesses rather than on the strengths of the CBO (see Chapter Four). The bulk of the

report consisted of a description of issues raised during interviews as well as the observations of the writer of the report. A summary of these is now presented, grouped into key themes.

#### ***5.9.1.1 Administration***

This function was shared between the project manager and the coordinator. There had been thoughts of handing over some control to the community health workers at Khayelitsha but an attempt in respect of petty cash had failed. Management saw this as resistance to change from the health workers and also felt that “Khayelitsha staff, and people in Khayelitsha in general, perceived the [CBO] as being far richer than it was, given that they rarely came across the large amounts of money reflected in budgets” (p.14). The report also suggested that the CBO establish procedures such as record-keeping for the clients, monitoring and reporting systems, and a clear policy on salary and conditions of services for both the community health workers in Khayelitsha and the staff at the local tertiary institution.

#### ***5.9.1.2 Locus of power***

According to the report, finances and funding represented an important part of control. “In many aspects it [appeared] that Khayelitsha-based staff run the [organisation], and do so effectively, on a day to day basis. One of the [management staff at the local tertiary institution] saw it as ‘the project runs itself’, perhaps underestimating quite how much is involved in day-to-day organisation” (p.15). There was awareness in the report that decision-making and control needed to be shared between the leadership (based at the local tertiary institution) and the health workers at the project site.



#### ***5.9.1.3 Planning and sustainability***

Strategic planning took place once a year and beyond this there was little planning: “People are bogged down with work; planning is luxury” (response from an interviewee, p.15). The report identified a need to involve the community health workers in the early stages of planning and decision-making, to ensure that decisions were appropriate and feasible in the Khayelitsha context. Other needs identified were:

- the formulation of a clear policy and strategy on the CBO’s involvement in community structures;
- the reduction of the CBO’s isolation by developing relationships with other NGOs, both local and elsewhere.

Overall the CBO was found to have broken new ground and to have achieved more than it had set out to do.

#### **5.9.2 Narrative Report (2002)**

Although this report was written at a time when arrangements for the organisation’s continuation were unclear and uncertainty and anxiety was evident amongst the community health workers, this report set out to investigate the planning (or lack of thereof) in the future management and sustainability of the CBO.

##### ***5.9.2.1 Control and Administration***

The report found that channelling funding through the local tertiary institution placed the financial management of the CBO within a well-structured and controlled system. However, this provided little opportunity for the community health workers to develop financial and management skills. Decision-making around the funds was only undertaken by members of

management at the local tertiary institution. The report also commented on the advantages and disadvantages of the financial control and administrative procedures.

#### ***5.9.2.2 Conflict of interests***

The report detailed a conflict of interests between the local tertiary institution on the one hand and the community and the community health workers on the other. The local tertiary institution saw the CBO as a project with service and research components. The report states that “universities are, at the best of times, difficult platforms from which to develop sustainable, grounded, community interventions. This is especially so in post-1994 South Africa where issues such as accountability, participation and transparency have become part of the socio-political lexicon and can determine the success and failure of intervention” (p.3). The CBO was also seen as offering both much-needed community service and employment, while at the same time providing meaning and purpose (for health workers and clients) in a very harsh environment. The desire of the community to ‘own’ the project was reported to have been very strong.

#### ***5.9.2.3 Individual roles, responsibilities and levels of co-ordination***

The report stated that individual roles and responsibilities had not been clearly defined. This had impacted on the way that the CBO was co-ordinated and managed. The situation was exacerbated by the imminent closure of the CBO. At the time in which the report was written, the CBO had enlisted the service of a development consultancy company to assist in this matter.

#### ***5.9.2.4 Planning and sustainability***

According to the report, the dedication, skills and goodwill present could have played a significant role in sustaining the CBO and its positive impact on mental health in Khayelitsha. However, without an appropriate organisational framework within which this could take place, it

was argued that the work was not sustainable. It was noted that planning was left late in the life cycle of the CBO and that there was a perception amongst the community health workers that they would be left with 'nothing' when the organisation closed, not even marketable qualifications. The report stated that if the CBO had spent some time on organisation and development it would have been in a stronger position. For instance it should have developed a shared vision, supported by a proper clarification of roles and responsibilities, with management training for the health workers at the project site and with assistance with fundraising. The financial crisis facing the organisation, therefore, revealed a lack of sustainability as well as a management vacuum amongst the community health workers and the community.

#### **5.10 Summary**

The CBO was started with a clear vision and with the aims of providing affordable mental health care for children and their families in Khayelitsha and of empowering the community. It managed to achieve the first part of its vision and created an organisation which was community-based and employed local people. However, the way it was structured seemed to make it difficult for the CBO to achieve its second goal. It did provide a good service to its clients in the community, but the community health workers felt that they were not being treated well and fairly by the CBO. The imminent closure in 2002 brought to the fore all these unresolved issues and their significance in the lives of the community health workers. It seemed that the community health workers felt traumatised by the process of closure and the way that management had handled the process. The dysfunction of the organisational systems was highlighted and the way in which they exacerbated the impact of the imminent closure on the community health workers. Responses to the imminent closure also reflected some of the social and political issues inherent in a post-colonial and post-apartheid society. The results raised many important issues and the

final chapter provides a discussion based on the most important of these. It also contains my conclusion and some recommendations resulting from this research.

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## CHAPTER SIX

### DISCUSSION AND RECOMMENDATIONS

#### 6.1 Introduction

Drawing on the literature that was reviewed in Chapter Two and Chapter Three, this chapter shows how these theories have assisted me in making meaning of my research findings. Douglas (2002, p54) citing Thorne (1997) argues that extrapolating meaning from research is critical: “[The] critique of qualitative research within the health sciences properly extends beyond mere adherence to the methodological rules and towards examination of the much more complex question of what meaning can be made of the research findings.”

In discussing my findings I have divided this chapter into three sections. Section A explores the macro issues raised by the research. These include the broader context and challenges faced by the CBO. The aim of this section is to highlight the macro-dynamic (organisational) issues and to consider whether the theories reviewed in Chapter Two and Chapter Three are applicable to the research findings.

Section B discusses the micro-dynamics of the CBO (individual issues) and shows the way in which the reality of imminent closure interacted with the internal world of the community health workers. The aim of this section is to extend the application of self-psychology and intersubjectivity theories in order to understand the impact of trauma. I also examine the role of the community psychologists working at the CBO. I begin this section by discussing my own intersubjective experiences and try to explain how they interacted with the intersubjectivities of the people at the CBO.

Section C contains my conclusion and some recommendations resulting from this research.

## **6.2 Section A: Macro issues**

### **6.2.1 Hope and Hopefulness**

The establishment of the CBO was founded upon a sincere wish to provide mental health services to members of a community who were clearly in dire need of such services. The provision of these services was based on principles of community participation and empowerment. The CBO documents, which were relevant for this research, indicate that these goals were established after a thorough research project had been conducted in the community and the need for such an organisation was clear. The CBO had clear objectives of providing affordable mental health and of empowering the community. The 'layperson model' adopted by the local tertiary institution in setting up the CBO is keeping with the approach used in community psychology which draws on people living within the community to provide services to the community (Swartz & Gibson, 2001). This approach also promised a source of employment, meaning and purpose in a community with a high level of unemployment (53% of its employable population). Consultation with community members raised expectation that this project would truly be a community-based intervention, owned by the community. The Narrative Report (2002) in chapter five indicates that there was a strong desire in the community to own this project.

The primary mental health model adopted, however, failed to recognise the imbalance of power relations between the local tertiary institution and the community (cf. Long, 1999). Results show that the local tertiary institution was 'naïve' in its approach and ignored the dynamics of race, gender, and class that underlined its intervention. Initial consultations with the community were based on the assumption that there was an understanding and commonality of expectations between the two parties. The research shows that the ideas of community participation and

empowerment were imposed on the CBO by external pressure both local (Khayelitsha civic organisations<sup>20</sup>) and international (funders).

The research results indicate that community participation and empowerment was a requirement placed on the local tertiary institution by the Khayelitsha civic organisations when the CBO was being set up. In addition, 'community participation' and 'empowerment' are words that are seen as increasing the chances of gaining funding. As a result, the CBO may have incorporated these principles as a way of projecting "the identity they would like to project to their beneficiaries, funders..." (Kihato & Rapoo, 1999, p.11; see also Harding, 1994; Shubane, 1999a). It is therefore argued that the concepts of community empowerment and participation became a vehicle for gaining access to the community and to funding, and the CBO did not think through what these concepts would mean for the organisation itself and its future.

### **6.2.2 Development and sustainability**

After the CBO had been set up, power remained in the hands of the local tertiary institution, with the community represented by only few individuals on the advisory board. The position of the advisory board in the organisational structure suggests that the CBO management did not regard its role as central to the running of the organisation. Further, the advisory board did not have a clear role and did not partake in decision-making, and as a result representation of the community in the CBO was not fully integrated into the functioning of the organisation. Apart from the nominal interaction provided within the advisory board, contact consisted of the community being the *users* of the health services provided by the CBO. This model reinforces both power relations and race relations – white people appeared to be doing something *for* rather than *with* black people (see Long, 1999; Taylor, 2002; Huna interview, 2004). Further, this model

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<sup>20</sup> The aim of these organisations is to protect the interests of the community members. Every community project has to be approved by these organisations.

positioned white people as the ones who possess and control the resources. This reinforced the imbalance of power distribution; white people were seen as being able to give and withdraw resources at will and to control the distribution of these resources (cf. Long, 1999; Hamber et al, 2001).

It seems that the CBO adopted the conventional path of 'sustainable' development, which has been shown to create dependency rather than sustainable development in communities (Taylor, 2002; Green & Matthias, 1997; Huna, interview, 2003, 2004). Its objectives assumed that the provision and improvement of mental health service would empower people (Taylor, 2002; Huna interview, 2004; CDRA Annual Report, 1997/98). A level of dependency was thus created: the CBO would not have been able to carry on without the local tertiary institution after its closure, since they did not have capacity in terms of skills and were not involved enough with the CBO to deal with its closure. It is important to note that the community was not involved in the process of closing the organisation – or even aware of it.

The relationship between the community and the local tertiary institution appeared to be a replica of the relationship between the North and the South, and colonial relationship reminiscent of South African past. In this case the community was the South/the colonised and the local tertiary institution, the North/the colonialists. The relationship between these two entities reflected the arguments that have been mentioned in the literature (see Taylor, 2002; Huna, interview, June 2003 & 4; O'Keefe, 2001). This research shows that the community health workers felt that the local tertiary institution lacked awareness of how it was impacting on them and the community negatively. In addition, the CBO management and the local tertiary institution did not make any attempt to incorporate the local community's skills into its operations in order to facilitate the sustainability of the organisation or of its services in the community.



There was no future planning in the way the CBO was managed; the organisation depended solely on donors and no other financial resources were considered. This meant that any decrease in funding made the CBO vulnerable to changes in funding climate and donors' demands (cf. Harding, 1994; Green & Matthias, 1997; Kihato & Rapoo, 1999). Because of the pressure to meet the demands and criteria of the donors, management appeared to have lost sight of the internal needs of the organisation. In addition, the lack of representativity of the community within the organisation and the absence of a full-time management based at the CBO contributed to poor communication and ongoing 'on the ground' evaluation and the understanding of the situation. The focus of the CBO became operational and external while organisational issues such as the psychological well being of community health workers, strategy and planning were ignored.

### **6.2.3 Skills Development**

From the outset, the CBO had problems with transformation and with transferring management skills to the community health workers. The community health workers' clinical successes were not acknowledged in the organisational structure in terms of career advancement and recognition. In addition, the training opportunities that the CBO provided were not linked to the community health workers' career development or to the vision or strategy of the organisation, so the training was set to fail. Management seemed to use training as a way of defending against their anxiety about the lack of career opportunities in the organisation. This confirmed the community health workers' notion that management was unwilling to give them opportunities in the organisation. In this way the CBO seemed to be taking a long time to adapt to the new dispensation in South Africa, instead perpetuating the racial imbalances that had defined apartheid society (cf. Swartz, 2004).

Almost ten years after its inception, the organisation was not only struggling to survive, but the community health workers were scarcely represented in its managerial structures. The structure of the organisation reflected some of the South African political dynamics; it was still managed by a historically privileged tertiary institution, and pioneered and led by a white male.

#### **6.2.4 “The unkindness of kindness” and the liberal ethos**

In South Africa, community empowerment and participation initiatives within community psychology have been criticised and found by local writers to be limited in their approach because they fail to address structural inequalities (Seedat, et al, 2001; Hamber et al, 2001). Despite the good intentions of these interventions, there is a danger that these approaches patronise and recolonise communities (Hamber et al, 2001). The literature discussed in Chapter Two indicates that there is a high prevalence of poverty, a history of poor service delivery and a lack of resources in communities such as Khayelitsha (Maw, 1996; Gibson, 2002a; Pillay & Lockhart, 2001; Moultrie, 2004). I would like to suggest that these factors put communities in a vulnerable position with respect to (well-intentioned) interventions because they cannot decline help. Dullabh (2000) found that people may accept help, even if it does not meet their needs because they are hoping that through this they will somehow be able to get what they really need. Although in this case there is no doubt of the need for the mental health service that the CBO was providing to the community, Dullabh’s finding highlights the vulnerability of communities that are in most cases not in a position to negotiate what is provided for or offered.

Nonetheless interventions such as the one represented by this CBO are needed and have a role to play in the South African context. Kindness is key in the recovery process of survivors of abuse and creates an opportunity for them to rebuild the trust that was shattered by abuse (cf. Brothers, 1995; Herman, 1997). However, I am also arguing that there is a need to think about the way

interventions are implemented, so that communities do not remain in the vulnerable position that they were in under the apartheid government. For instance, the management of the CBO exacerbated the problems of the already vulnerable community and of the community health workers. Valerie Sinason<sup>21</sup>, citing one of the survivors of multiple abuse that she works with said, “Annie Caruso speaks of the ‘unkindness of kindness’. When an abused victim or survivor is treated with kindness they are put in the most vulnerable, unbearable moment of trust that repeats where they were before abuse. That’s bad enough, but then if the new relationship repeats or re-enacts then there is betrayal again” (personal communication, April 2004). The threat by white management of imminent closure repeated for the community health workers an experience of white people who are perceived to have the means to offer assistance, do so momentarily, but then withdraw support. The fact that the community had not been informed about the imminent closure caused further wounding, that is, re-iterating that the needs of the community health workers and the community are not paramount, but subordinate to the agenda of white management.

The next section discusses the impact of these macro issues on the community health workers and on their understanding of the imminent closure.

### **6.3 Section B: Micro issues**

#### **6.3.1 Introduction**

In considering the meaning of my findings, I found that the research indicated that the response to the imminent closure of the CBO reflected a three-layer reaction from community health workers, as indicated below in Figure 1. The imminent closure was repeating trauma at personal,

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<sup>21</sup> A psychoanalyst who is a consultant to CGC, UCT and a well published author in the field of multiple trauma

organisational and community levels. This repetition of trauma reflected a continuous interaction between the present and the past experiences of the community health workers (cf. Mitchell & Black, 1995; Stolorow, 1984, 1995; Stolorow & Atwood, 1992; Russell, 1999a).

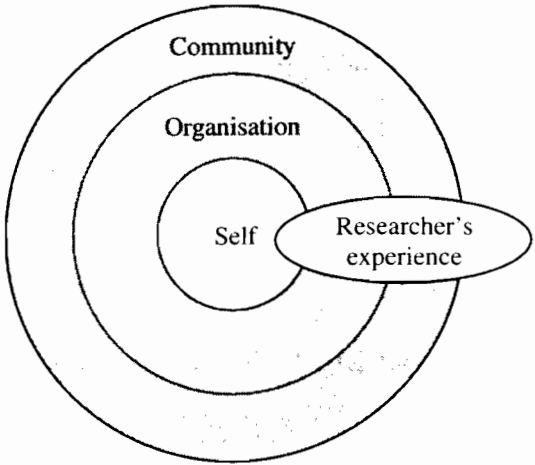


Figure 6.1

The layers shown in Figure 6.1 are informed by own subjectivity in terms of how I drew meaning from this research. This is represented by the 'researcher's experience' on the diagram. Various layers of my identity have informed the ways in which I have constructed what I perceive and regard as 'truth' in this research. This was also informed by my feelings and reactions at the time. Russell (1999b) contends that "the thing that is remarkable is that the affect at a given moment, for a given person, with a given history, in a given situation, is utterly accurate and unerring... There is, therefore, no such thing as a final, objective historical account" (p.38).

In discussing these layers I will be using self-psychology and intersubjective models. The self-psychology model emphasises the importance of the self-experience in the selfobject matrix, which is a form of interpersonal interaction (Teicholz, 1999; Mitchell & Black, 1995; Stolorow, 1984). The intersubjective model builds on the concept of experience of self and suggests that

there is a continuous interaction between two or more intersubjective experiences. Intersubjective theory also suggests a connection and flow between an individual's inner world and the intersubjective experience. In the next section I will discuss the 'researcher's experience' shown in Figure 6.1. A detailed discussion of the significance of each of the three layers follows thereafter.

### **6.3.2 The researcher's experience**

In this section I will consider my transference and counter-transference, as a researcher in this process (cf. Bollas, 1992). I will begin with my first contact with the CBO, which will cover my experiences with the community health workers in the staff support group. Then I will discuss my counter-transference during the interviews and while I was analysing this research. In this way I will try to explore what the interactions evoked within me, and which particular aspects of the experience repeated my past (cf. Russell, 1999a).

I was a student when I first entered the CBO in 2002, but the relationship I was entering into between the staff support group and the CGC had already been established six years previously. I had worked as an Organisation and Development (OD) consultant for eight years prior to my clinical psychology training. My hopes of adapting and applying psychodynamic theory to my work with the CBO during 2002 were therefore informed by my previous experience of working with a multi-disciplinary and organisational systems approach. This placed me in a difficult position because on one level I was aware of what could be done to assist the organisation through this difficult time (here I was competent), and at another level I had no experience of what to do in a psychodynamic therapeutic group (here I was incompetent). This often left me frustrated because I felt that as facilitators we could do more, and that merely providing a containing space and our empathic understanding was not enough.

Adopting an empathic, therapeutic stance felt to me at times as if I was protecting the community health workers from engaging with the reality of the situation and leaving them unchallenged. Engaging empathically also felt at times as if I was colluding in promoting their sense of helplessness. However, I kept my hopes and frustrations to myself and I did not raise them with the community health workers, although I did discuss some of them with my colleague and with my supervisor. I managed to establish a role for myself in the group as a co-facilitator and took the opportunity to raise things that I thought were important, but most of the time I doubted my own observations and felt challenged by the psychodynamic framework. I felt that my past consulting experience was 'interfering' with the therapeutic process (cf. Russell, 1999a; Bollas, 1992).

I also became frustrated with the community health workers because I felt that if they were not happy with the organisation they should find other jobs and resign. Yet on the other hand I was very angry, even enraged, at the way in which management was treating them. I perceived management to be oppressive and disrespectful, however it was difficult to 'know' who or what management was because I was only exposed to the perceptions and views of the community health workers. This confusion and frustration informed my need to ask particular questions in the interviews, in order to help me to understand.

Another aspect of my identity which informed my experience of and reaction to the CBO group was that of being black and a woman. Both my race and my gender made it easy for me at times to identify with what the community health workers were feeling. Their oppression and exploitation by management, who were predominantly white, resonated with my past experiences. In addition, our mother-tongue (Xhosa) was the same and I could understand when the group members switched to Xhosa during the sessions (they used Xhosa to communicate their

feelings, particularly difficult feelings). I was the only facilitator who could understand when the group switched to Xhosa, which seemed a natural extension of the discussion during staff group sessions. But, I was younger than most of the community health workers and more educated, I belonged to a different generation, and had graduated from my family's working class status. Politically, I was part of a generation whose anger had made the country ungovernable. Lastly, I had left a prosperous career in the private sector to enter the clinical psychology field. All of these made me feel that I was merely creating in my own mind an illusion of similarity between the community health workers and myself, because my identity of being black and a woman from a working class background did not mean that our experiences were similar. This suggested that our experience within these identities were not homogenous but complex and we experienced them differently. All this left me confused; I felt guilty for being frustrated with the community health workers, because they seemed to take up the victim position, yet I knew that they had not and, in their current circumstances, did not have the choices that I had and do have (cf. Bollas, 1992). Nonetheless, I felt impatient and angry with the community health workers for feeling so helpless, dependent and for not fighting back. I desperately wanted the therapeutic process (treatment) to make it possible for the community health workers to see what they possibly repeating (cf. Bollas, 1992; Russell, 1999a). This feeling was underscored by repeated requests from the community health workers to us (facilitators) to help them find jobs.

The feelings and thoughts evoked in me by the community health workers were confirmed for me in the second group session, when the community health workers explained why they found it difficult to raise their dissatisfaction with management. They said that they were part of an older generation and that the new generation (younger people) would find it easy to do this. They were thus communicating feelings of helplessness. Their helplessness reflected their gendered/raced position: black women, who were part of a different generation. In this way their overwhelming

feelings of helplessness in the broader society were powerfully re-evoked by their position at the CBO (cf. Flax, 2004).

The community health workers' past experiences interacted with the imminent closure of the CBO in such a way that the experience was re-traumatising. As Russell (1999b) points out the trauma "reside[s] at an interface, both sides of which are necessary components of the injury. One side is a reality situation that is assaultive, overwhelming. The other side is a wish that has destructive potential and becomes, in some measure, actualised" (Russell, 1999b, p.26). The trauma for the community health workers contained both of these sides; they were hurt: "we need bandages and panados", and insulted by management: "we are 'kaffirs' with short hair". They complained that management treated them as if they did not have feelings. The other side reflected the destructive potential of the community health workers, for instance in the second session most of the staff support group was almost manic and in a euphoric mood; there was a sense that they were going to 'savage the beast' (management).

It seems to me that I have been confronted in this research by the paradoxes in the growth of human feelings which Russell describes (1999a). The growth was challenging to my experience in management consulting, where 'there is a solution to every problem', and where being an expert is 'doing'. It also evoked my own early experiences of trauma. Letting the paradox teach me has been a very difficult experience because I have had to grapple with and recognise my own feelings. The process was very slow and took some time to emerge and I am still not sure whether I have mastered it. However, drawing on Russell (1999a) the following paradoxes in the growth of my feelings were highlighted:

- Was it me or the community health workers?
- Did I do this or was it done to me?



- Is it now or was it then?
- Can I choose what I feel?

These questions indicate my struggle to articulate and differentiate the community health workers' feelings from mine. Sometimes being confronted by their 'innocence' left me feeling guilty and more confused: is it them or me? (ibid.; Bollas, 1992). However Mitchell (1999, p57) argues that:

In poignant emotional moments, it is neither possible nor necessary to sort out me from you. At points of personal growth and transcendence, it is neither possible nor helpful to distinguish what was done to me from what I generated myself. In the richest affective experiences, it is neither possible nor enriching to distinguish between now and then.

This quote resonates with me because it remains difficult for me to differentiate what belonged to the community health workers, what belonged to my colleagues and what belonged to me. Were my feelings evoked by the material from the research that I was currently working on, or by what had happened in the past while I was working with the group and conducting interviews?

At times I became frustrated with my co-facilitators because there was another level of different intersubjectivities and approaches interacting with mine. To illustrate this I will use an extract (below) based on the notes on the group session, which was attended by a UK psychoanalyst, referred to in Appendix A. The UK psychoanalyst visited the community health workers annually. In the session, she stated that she was very disappointed about the imminent closure and the way management had handled the situation. Her intention was to arouse the group into action but, the community health workers were ambivalent about taking action and expressed fear for repercussions. The session seemed to have evoked feelings of dependency and vulnerability, which were reinforced when the UK psychoanalyst gave the community health workers money.

The group wanted to be rescued and the UK psychoanalyst gesture raised the possibility and hope that something could be done to save them. The group session also aroused emotions for the psychologists-in-training and as I have mentioned earlier, it showed different subjectivities that existed amongst the facilitators:

*It was clear arriving back at the clinic that my colleague and I were holding different experiences of what happened earlier in the session. My colleague was angry and I was more optimistic. We had experienced the visiting UK psychoanalyst very differently. My colleague had experienced the visiting UK psychoanalyst as not understanding the position of the group in their position of powerlessness with respect to management, while on the other hand I had felt that the group needed to be pushed and affirmed, encouraged to believe that there was something they could do. I felt it was imperative for Shireen to come back to the group because it would address the their projection and transference on her. In this way the group will be able process the impact of the trauma and will move to a place where they are able to think and act. My colleague felt that this should not have been done without the consultation of the regular and absent group members. This raised many issues around the role and authority. For instance, who brings issues to the table and how this is complicated by termination that has been poorly managed. In supervision it became clear that the group's defences around this were symptomatic of a management style that was in itself defensive. Our supervisor felt that it was good that we attempted to bring some cohesion in the group and that we would battle with this throughout. It became clear that my colleague and I had carried the group's split to such an extent that it took a long while to create cohesion and reflect on the session (it took us 3 weeks to write the notes of this session). We were able to experience the emotion that was so overwhelming and acknowledge how uncomfortable it was to continue the split and deal with reality in this way even though it was disabling, so that we*

*were not able to be constructive with our rage. Sandise seems to encapsulate this in her increasing anger with every session and yet feeling stuck.*

Of course, my reactions and feelings were informed by my own intersubjectivity and therefore, the discussion of the results of this research are embedded in and informed by my own transference, my past, and my repetitions (see Russell, 1999a; Bollas, 1992).

Bearing this complexity in mind in the next section I will discuss the other three layers in Figure 6.1. I begin with the community layer; a discussion of the organisational layer follows, and I conclude with the self-layer.

### **6.3.3 The community's experience**

In the outermost (community) layer shown in Figure 6.1, the community health workers, located with their context, had two responses to the CBO's imminent closure. The one response was to the loss of their ability to provide for their families, since they were the breadwinners. The other response was to the loss of providing for the community through being their 'helpers' and carers. The imminent closure threatened to take away the selfobject experience of being valued and needed both by their families and by the community (see also Brothers, 1995; Lachmann & Beebe, 1992). Fulfilling this important selfobject experience for others protected the cohesive sense of self and survival (Lachmann & Beebe, 1992; Mitchell & Black, 1995).

The imminent closure threatened the role that the community health workers played in providing for both their families and the community. They felt important in the community and believed that they were playing an invaluable role in providing mental health care. In this case the positive selfobject experiences gained through the work came from outside (clients) rather in from inside (the CBO): their clients in the community and their families maintained the community health

workers' self-esteem. The community health workers felt mirrored by the community which provided the recognition and acknowledgement they needed (cf. Stolorow, 1984; Basch, 1984, Swartz, 2000). The imminent closure therefore threatened their sense of value and worth that was being provided by these selfobject experiences.

By way of an example, the following extract from the staff support group (Session 8) reflects the community health workers' anxieties about abandoning and failing the community. One of the community health workers had had a car accident. She was picking up one of her colleagues from home and was waiting outside. The car started to move and the brakes failed to work. The car ran out of control, crashing into the toilet of a local resident, destroying it. The owner of the toilet was very angry and almost attacked her. She felt that in this incident her identity had been undermined and her contribution not recognised. She had been blamed for an accident that was unavoidable and this reinforced her experience of unfair treatment which she had also been subjected to by the CBO, particularly when she had only provided care. The feelings of being uncared for were highlighted by this incident and heightened the community health workers' fear of abandonment. It may be argued that symbolically, crashing into toilet is an expression of the rage (part of which was narcissistic), which the community health workers felt towards management for their unavailability, and lack of empathy (cf. Lofgren, 1984).

Yet, despite the trauma that the community health workers were experiencing during 2002, they remained committed to their clients. Providing for their community and families was crucial for the community health workers' survival and self-cohesion. Their sense of connectedness and their personal commitment had helped them provide a service, despite their dysfunctional historical background and that of the CBO. They had strived against all odds (their own traumatic

backgrounds, political oppression, and difficult working conditions) and had managed to sustain themselves, and the imminent closure threatened all of this.

This research highlights an interesting point about the meaning of resistance and resilience in South Africa. The commitment of the community health workers was mainly about making a difference to their community and their country. It also echoed the voice of the struggle, which suggests that their resistance was fuelling a revolutionary spirit. This seems to be inherent in the South African resistance and struggle history. Our history has given us an opportunity to experience resistance as fuelling resilience, epitomised by the rise of highly organised resistance against apartheid, which sustained itself through many years of oppression, when it overcame apartheid it provided a structure that was ready to take over a country. This resistance defied the chaotic and dysfunctional system of apartheid and remained focused on its primary goal. The situation which had arisen within the CBO seems like a re-enactment of this broader history: the CBO management and its handling of the imminent closure is reminiscent of the oppressive regime and the community health workers are cast into the role of resistance fighters. I am amazed by the work that they were doing despite the dysfunctional organisation they worked in. The work that they were doing, both providing healing for the community and taking care of their families, is linked to their own recovery from their traumatic backgrounds; it is a reparative way of correcting the wrong that was done. Herman (1997, p. 236) puts this very clearly and states that the sense of connectedness is important to survivors of trauma and particularly to their recovery:

Commonality with other people carries with it all the meanings of the word *common*. It means belonging to a society, having a public role, being part of that which is universal. It means taking part in the customary, the commonplace, the ordinary, and the everyday. It also carries with it a feeling of smallness, of insignificance, a sense that one's troubles are 'as a drop of rain in the sea'. The survivor who has achieved

commonality with others can rest from her labours. Her recovery is accomplished, all that remains before her is her life.

The imminent closure threatened to take away the opportunity for the community health workers to be involved, not only in assisting the community with its recovery from trauma but helping them to deal with their own pain as well. The closure threatened to take away the only thing that gave meaning and had made living in their current traumatic conditions bearable.

#### **6.3.4 Organisation experienced as traumatising**

The second layer shown in Figure 6.1 represents organisational trauma, with the CBO being experienced by the community health workers as an abandoning object (cf. Stolorow & Atwood, 1992). Its imminent closure brought back the unprocessed traumas that had characterised the apartheid era. The way in which each race was subjectively constructed and internalised in the past was being re-enacted in the present (cf. Flax, 2004). The failure of the organisation to contain the anxieties (trauma) of the community health workers was interpreted and understood as being the same as the way the white government (or even white people in general) had treated black people during the apartheid era. Borrowing terminology from Russell (1999a), one could say that it was the 'scars and the marks of apartheid' that were being evoked.

It had been argued that trauma happens as a result of repeated failures in the selfobject matrix (Mitchell & Black, 1995; Stolorow & Atwood, 1992). The inability to protect and look after what is good in interpersonal interactions results in trauma. Management at the CBO had failed to handle the organisation in such a way as to maintain the self-esteem and self-belief of the community health workers. One of the common themes in this research is the lack of attunement of the CBO management to the community health workers' needs (Stolorow & Atwood, 1992). The community health workers' traumatic experience at the CBO was embedded within the

relational milieu and called attention to the collapse of the attunement of affect between management and the community health workers (Russell, 1999a, 1999b; Stolorow & Atwood, 1992; Basch, 1984; Swartz, 2000). The collapse had its roots in the hairline fractures in the establishment of the organisation, which had failed to think ahead to future needs.

The failure of management to communicate and respond emphatically to the community health workers became traumatising and placed the health workers in a position where they had to contain themselves (see Russell, 1999b). Management, however, did not seem aware of this and seemed to have lost perspective on their actions. This seemed evident when I reviewed the CBO documents, the staff support group session notes, and conducted interviews. The following example shows how management in retrospect understood the behaviour of the community health workers, which emerged through the interviews I conducted. During his interview, one of the management interviewees said that he did not understand why the community health workers were so angry at management and that he had only picked this up in 2003 after he read a report from an external development organisation. I was struck by his lack of awareness and asked him why he thought the community health workers were angry. He thought about this for a very long time. There was a significant silence in the tape which recorded this interview, and for a while I thought I had lost some information. His eventual response was startling because, with violent assertions of innocence, he repeated himself and insisted that he found it completely unexplainable that staff could be so angry, particularly towards him. I found his reaction confusing; I had expected him to acknowledge some degree of responsibility. Bollas (1992) suggests that “all psychoanalysts are familiar with denial: the analysand’s unconscious need to be innocent of what is often most troubling” (p.167). This seems to me to be exactly what was happening here.

The respondent continued to suggest that the project manager might have stirred up things so that the community health workers would blame him; “by being innocent, the subject provokes the other to speak the truth and sometimes sustains innocence in order to maintain some contact with the repudiated content. By provoking the other, the violent innocent stirs up distress, ideational density, and emotional turbulence in the other” (Bollas, 1992, p.169). In this instance I felt compelled to reframe and ask the question in variety of ways to see whether the respondent would realise and accept that the way the imminent closure was handled had caused injury and traumatised community health workers, but this was again met with denial.

Organisations, like individuals, tend to adopt unhealthy defence mechanisms to assist them in managing anxiety (Halton, 1994; Obholzer & Roberts, 1994). Bollas (1992) argues that a person denies a perception because it is distressing. In an attempt to deal with the distress, the person refuses to take responsibility for her/his action and instead puts the blame on the ‘other person’. In this case the project manager was blamed, standing accused by the community health workers of colluding with management to betray them, and by management for ‘stirring things up’; she was scapegoated by the organisation. Denial is a key defence mechanisms, and here it inhibited the organisation from recognising its own destructive patterns (Halton, 1994; Obholzer & Roberts, 1994; Bollas, 1992). In this way the organisation was ‘able’ to deal with the stressful situation while continuing to be oppressive towards the community health workers.

The failure of management to contain community health workers also impacted on our (facilitator and psychologists-in-training) therapeutic relationship with the community health workers. There was a paradoxical wish, which created a split within the staff group because at one level they wanted us to look after them, while at another level they rejected us and our potential to help, and were ambivalent towards the sessions. There were few sessions in which all the community



health workers were present. The sessions took a lot of time to get started and we were never sure that they would actually take place, although they always did. The behaviour of the community health workers reflected their struggle to trust us, because of the betrayal of trust in their self-object relationship with management (cf. Brothers, 1995). Given this, our approach to the group therapeutic process had to be a flexible approach; for instance we did not start the sessions till everyone was ready, and we allowed the community health workers to leave the sessions to attend to their clients. As facilitators we were caught between repeating empathic attunement (unlike management's approach) or repeating the empathic failure by calling into question their behaviour.

Drawing on Bion (1961), the organisation could be seen in the role of 'container'; holding its employees. It seems that this role had been problematic from the beginning. Firstly, the CBO was geographically separated from the local tertiary institution. This separation need not have posed a problem, there are many organisations that operate in this way, however, in the case of this CBO, the management was part-time, which meant that there was no-one who was dedicated full-time to the overseeing of the CBO. The local tertiary institution was only involved in managing and administering the donor funding, so their relationship with the community health workers was defined by money. The absence of a consistent presence linked to the powerful tertiary institution may have deprived the community health workers of positive self-object experiences which could mirror their value and allow their sense of worth to the CBO to develop positively.

The way in which the relationship between the local tertiary institution and the CBO was structured did not encourage cohesiveness and clear identity for community health workers. There was a lack of unity between the CBO and the local tertiary institution was absent and the constant changes at management level made it difficult for the community health workers to form

the idealising experience which is needed for the positive experience of self. The lack of an idealised leader created a feeling amongst the community health workers of being neglected and unimportant, causing a narcissistic injury (cf. Lofgren, 1984). In addition, there was also an ongoing, underlying worry that the CBO would run out of funds and would close, which would have made it difficult for the community health workers to lose their fear and merge.

The development of an idealising transference through transmuting internalisation (Lofgren, 1984; Swartz, 2000) failed to take place because there were few organisational systems in place at the CBO which could facilitate the repair process of the psychic functions that had been disrupted. I would like to suggest that the community health workers would have been able cope better with the idea of the impending closure if the CBO had established effective performance management systems, communication channels and clear roles and procedures. These systems could have ensured that the community health workers received regular and consistent feedback about their performance and about events surrounding the imminent closure. The dysfunctional organisational systems created a pattern of failure in meeting the needs of community health workers (cf. Stolorow, 1984; Basch, 1984; Swartz, 2000). It became difficult for the community health workers to internalise their strengths and trust in their own worth in the absence of a good idealised object (the organisation), particularly in the absence of systems that reinforced positive self-esteem.

Within such a context, the trauma of the imminent closure called all the relationships in the CBO into question (cf. Brothers, 1995; Herman, 1997). The organisation split into different factions (as discussed in Chapter Five), and the levels of distrust heightened between management and community health workers and also between the community health workers themselves. This breakdown was recognised by management and encapsulated in the following quote: “the trauma

of last year is a trauma of a near death experience. The relationships were broken down ... and staff became paranoid about each other” (management response interviews). The fact that some of the community health workers were not being retrenched created even more mistrust and division. Those that were staying on felt guilty and ashamed, and saw their retention as a betrayal of their colleagues.

### **6.3.5 The experience of trauma on self**

The innermost layer in Figure 6.1 signifies the meaning of the trauma to the self. As I have mentioned earlier, I am using a self-psychology model (discussed in Chapter Three) to understand the individual response of community health workers. At this level the imminent closure evoked past trauma and losses. I hypothesise that the trauma repeated organising principles about loss and abandonment formed in the earlier life experiences of the community health workers (see Stolorow & Atwood, 1992). The evocation of past trauma was clear and made explicit by one of the community health workers in an interview with me, she stated that she perceived herself as both an employee and a client of the CBO. She stated that she had had a traumatic life and had the services provided by the CBO been available at the time she would have used them.

It is important to mention that although I am making assumptions about community health workers’ past trauma and the impact of that trauma on the selves of community health workers, these assumptions are based on the real experiences of the community health workers as black, and as women (except for one male, community health worker). In addition, the fact that they lived in a poverty-stricken and violent community suggests that they were very likely to have been survivors of personal trauma.

The staff group session notes and my interviews with the community health workers strongly suggest that the imminent closure of the CBO shattered a sense of self amongst the community health workers (cf. Brothers, 1995; Herman, 1997). They struggled to recognise their own value and worth, tending to shrug off and ignore compliments or comments that highlighted their personal value. As group members they did not engage with such observations and appeared to be unable to come to terms with positive feedback and affirmation. The subjective experience of the imminent closure and the interaction of this with the events surrounding the closure defined the trauma for the community health workers, who displayed a disturbed trust in self (see Brothers, 1995; Moultrie, 2004).

The community health workers internalised the imminent closure of the CBO as betrayal of self-trust (see Brothers, 1995). In Session 3, they mentioned that management had officially informed them that the CBO would be closing in seven months' time and that they would all be retrenched. Joyce asked what had happened to the half million rand (R500 000) that had been raised for sustaining the project beyond December 2000. Nomsa explained that management had used these funds as part of the retrenchment packages and to keep the CBO going for another few months, rather than depleting funds so that no compensation could be made to the employees, which would in any case be falling foul of the law. Joyce was unconcerned about the technicalities and possible 'truth' in Nomsa's response that management had not misappropriated funds and seemed convinced of management's betrayal. In the betrayal of self-trust "the glue of selfobject relatedness between self and others is loosened, causing selfobject fantasies to shatter" (Brothers, 1995, p.232). Joyce's distrust in management seemed to be a defence mechanism, helping her to avoid fragmentation and being overwhelmed by the trauma caused by the imminent closure (cf. Brothers, 1995). It also reflected anger and rage at management who were perceived as an abandoning object (cf. Benjamin, 1990; Lachmann & Beebe, 1992).

Brothers (1995) suggests that as the self becomes disorganised by trauma, survivors experience unbearable anxiety and feelings of shame and anger. As a way of coping with this pain, community health workers adopted defence mechanisms such as avoidance and denial. For instance, in Session 3, the staff group members showed different facets of the community health workers' experience of trauma. Nomsa who was sitting by the heater, began to nod off and eventually fell asleep. Musa appeared to be in denial of the practical implications of the closure. He appeared quite surprised and amused by Joyce's extensive and realistic plans, which included studying industrial psychology course in the management of HIV/Aids in the workplace. Sandise was thinking of selling clothes. This evoked a strong negative reaction in the facilitators about the possible loss of skills that would occur when the project closed down, which highlighted our (facilitators) unconscious organising principles about rescuing.

In the staff support group there was a definite lack of urgency and denial that the CBO was going to close, reflecting a sense of powerlessness (see Herman, 1997). Nomsa commented that she had never heard of an organisation that closed 'totally'. At this stage other group members tried to think of other organisations but could not find any that had 'totally' disbanded. This seemed to sustain the fantasy that the CBO would not close, so there was no need to deal with pain. This was confirmed by one of the community health workers when she admitted in the session that: "none of us have looked for a job". In Session 4 the staff group members were quiet and exhausted. Joyce, Nomsa, and Sandise fell asleep and other members appeared to be taking strain. The group discussed the meaning of 'sleep'. We saw this as representing the need of the group to protect itself from psychic pain.

In Session 8 the group mentioned that they had now been told that some of the community health workers would not be retrenched. They did not know which of them would remain behind.

However, all of them had received a short retrenchment letter which detailed their retrenchment packages, without any indication of how these had been calculated. They referred to the letter as 'the love letter', which showed their cynicism and rage about the way they were treated by management (cf. Brothers, 1995). The shortness of the letters was perceived as dismissive and reinforced their perception that management was unappreciative and did not see them as important. This reinforced their sense of powerlessness. Nomsa spoke about the fact that she was a single mother, living with her two brothers. One of the brothers had three children, two of them adolescents, who were also staying with her. She mentioned that her brother was neglecting his children and that she had to look after them, as well as her own children. She was angry with her brother, but shrugged off suggestions from the permanent facilitator regarding extraction of maintenance from him. Her sense of helplessness in her home life mirrored the helplessness she felt in the situation at the CBO. In both situations she felt abused and with no recourse to action (see Russell, 1999a).

Musa also spoke about his difficulty in sharing his anxiety about retrenchment with his wife. He felt isolated and the closure had raised issues about his masculine role and his ability to take care of his family. He was anxious about losing his status as the head of the household. He was experiencing the trauma as an assault which threatened his dignity (see Herman, 1997). This was particularly salient for him in a patriarchal context as an 'African man' and this raised feelings of shame and guilt in him. The image that I had of both Nomsa and Musa was of people who were experiencing their pain in isolation with no support from family (cf. Herman, 1997; Moultrie, 2004); "there was a loss of the containing envelope of the illusion of safety provided by human attachments, and it was the assault to this, to the containing structure, that constituted the trauma" (Russell, 1999b, p.28).

The next section examines the role of the community psychologist in this context and discusses some of the key issues raised in chapter five.

#### **6.4 The community psychologist's role**

The imminent closure of the CBO raised a number of issues regarding the role of the community psychologist working in a community-based organisation. A question raised in Chapter One was: when working with CBOs in crisis, can we focus our intervention only at micro level, or do we need to find ways to integrate our role with the broader organisational system?

My experience of the group, subsequent interviews, and review of the organisation documents suggest that the psychological intervention at the CBO existed within a complex context, which was embedded within race, gender, and class power relations. These differences also characterised the relationship between the community health workers and psychologists. The context required the psychodynamic approach to take these power imbalances into consideration (cf. Long, 2002). Given this background the role of the psychologists became broader than the traditional therapist's role; the permanent facilitator's interview responses show that her role included mentoring the community health workers. In addition, the permanent facilitator mentioned that it is difficult for therapist in a community setting to remain neutral because the nature of the work requires them to share information about themselves. It is therefore difficult in a South African context to ignore the impact of the socio-political conditions on the therapeutic framework (cf. Maw, 2002; Swartz, 2004).

Further, the results of this research suggest that it is also difficult to ignore the impact of the functioning of the organisation on the psychological intervention. For instance, in the face of the imminent closure in 2002 the community health workers were struggling to function (cf. Halton,

1994; Gibson, 2002a). The imminent closure re-evoked the power imbalances between the community health workers and the management of the CBO, and the split between black and white was exacerbated by the trauma. The exclusion of management in the staff support group may be seen as a fundamental flaw in the approach of CGC because it maintained the split in the organisation. In addition, one of the management responses suggested that the effectiveness of the staff group was also affected because the community health workers continued to spill over after the sessions and were uncontained. This respondent suggested that the community health workers needed more assistance in terms of making sense of the organisational dynamics and the broader context (CBO). This suggests that the therapeutic relationship between the CBO and the CGC in 2002, had remained at the micro level and reinforced the split in the organisation between the community health workers and management. During her interview in 2003, the permanent facilitator reported that the recent inclusion of the new project director in the support group had work well and has made a difference in the functioning of the group. It had allowed the community health workers to reflect on their own behaviour in the therapeutic space.

In her study, which examined the role of regional psychologists in the Western Cape, South Africa, Douglas (2002) suggests that:

...psychologists, by nature of their training, together with their skill of being able to take a 'meta' position and think about process, have a significant role to play. They can introduce creative and critical approaches ... in training and support of other health care workers and in their engagement with other members of the health team. They bring a crucial alternative voice, if efforts to develop mental health services are to be proactive rather than merely reactive (p.65).

Working at the CBO in 2002 the permanent facilitator and the psychologists-in training were confronted by a complex traumatic situation. As I have discussed in this research, in a traumatic



situation the past is re-enacted and enmeshed with the present. As a result, it became difficult to challenge the behaviour of the community health workers without risking retraumatising them. In a way the nature of the trauma of the imminent closure seemed to have made it difficult for the psychologists to bring an alternative perspective that was needed, and instead it was clouded by the dynamics of the imminent closure. It became difficult to maintain cohesiveness in the group and impossible to avoid the repetition of trauma. The trauma of the imminent closure made the situation at the CBO intractable.

## **6.5 Summary**

In this chapter I started with a discussion of the macro issues and their impact on the way that the CBO's goals and objectives were developed. Issues such as the scarcity of funding made the CBO vulnerable to external pressures. The difficulties it experienced in adapting to transformation were also discussed. Section B highlighted the dynamics underlying the difficulties within the organisation and the way they affected the community health workers at both community, organisational and personal levels during the time the CBO was facing closure. Finally key issues were raised in terms of the community psychologist's role. This following section provides a conclusion, and some recommendations are made regarding the role of the community psychologists working in a CBOs context.

## **6.6 Section C: Conclusion and recommendations**

### **6.6.1 Conclusions**

The aim of this research was to explore the reasons that the imminent closure at the CBO became traumatic and raised powerful emotions for the community health workers. It also explored the role of community psychologists working with community-based organisations that are dealing

with trauma. The results of this research indicate that there was a multi-layered response to the imminent closure of the CBO. This was a traumatic time for the organisation and evoked past traumas that had occurred at community, organisational and individual levels. The trauma consisted of the unresolved political issues that the CBO inherited when it was founded. The reaction of the community health workers to the imminent closure was marked by anger at management's betrayal. The failure of management to contain the anxiety and distress of the community health workers was understood as similar to the way white people treated blacks in South Africa. The re-enactment of trauma was therefore embedded within race, gender and class power relations. In addition, the dysfunction of the organisational systems exacerbated the impact of the imminent closure on the community health workers. This research showed that the CBO had not adapted to the new dispensation and as a result the past continued to dominate the present.

Bearing this in mind what follows are my reflections on the implications of the above on the role of the community psychologists working in community-based organisations and on future research.

## **6.6.2 Recommendations**

### ***6.6.2.1 Implications for role of community psychologists***

The difficulties and complexity of working with an organisation that is facing trauma has been highlighted in this research. The work demands incredible patience as community psychologists are required to witness clients repeating behaviours that may be damaging and psychologists have to contain powerful emotions whilst resisting the temptation to interfere with this process to make things better. The permanent facilitator from CGC reported that her long-term relationship (six years) with the community health workers is now beginning to show some progress, and the

community health workers are beginning to challenge each other and their behaviours. The community psychology interventions need a long time to make any significant impact to the patterns of relating. The therapeutic relationship is therefore required to contain the paradox of allowing patients to act out their repetitions and at the same time create a space for them to reflect and think through the issues that dominate their lives.

The dysfunction of the organisation poses another challenge for both the therapists and community health workers. While the therapeutic relationship is attempting to provide a different self-object experience, the community health workers have to continue to work in an environment that does not recognise their self-worth and basic needs. In this case the therapeutic relationship is caught up in a cycle wherein the ubiquitous impact of traumatic relationship with the management becomes difficult to escape, especially if management is not part of the therapeutic contract.

This means that while the community psychologists are working at micro level (with the staff support group) the organisation as a whole system should be held in mind. That is, the role community psychologists forms part of the broader action within which the therapeutic alliance is embedded. Furthermore, this also implies that community psychologists cannot aim to change this context without extending their role to include consultation and advocacy (cf. Maw, 2002).

#### ***6.6.2.2 Research Implications***

The use of a single case study can provide a means by which to understand complex situations that are often difficult to comprehend (Stake, 1995). Further, studying the CBO as a unit of analysis has placed the pertinent issues in this case study at the forefront. This case study showed how during the imminent closure, personal issues, were intertwined with social, political,

economic issues. This kind of research could be used to inform a community model and training of psychologists' students.

Research is needed to ascertain the subjective experience of the community health workers of our intervention at the CBO. This information could also be used to inform and improve the future interventions at the CBO, because the permanent facilitator has continued to work with the community health workers.

#### **6.6.2.3 Theoretical Implications**

The majority of research in the field of group and organisations draws mainly from the classical psychoanalytic theories such as Klein and Bion. The use of psychodynamic principles of the self-psychology and intersubjective theories proved useful in this research. It provided a useful guideline in the understanding of the way in which the community health workers internalised the experience of the imminent closure. Intersubjective theory allowed me to interrogate my 'baggage' and what I brought to the therapeutic relationship. Drawing on this I could better understand my frustrations while working with the community health workers at the CBO. It became clear that there were separate intersubjectivities that were interacting and affecting each other (cf. Benjamin, 1990; Stolorow, 1995; Stolorow & Atwood, 1992). The self-psychology theory highlighted the importance of the self-object and the development of a positive self-esteem and especially of an empathic engagement. The combination of the self-psychology and intersubjective theory made it easier to understand the complexity of trauma at the CBO. These theories highlighted the intractability of trauma that is embedded in gender, race, and class power relations. In this research these theories are regarded as important and suitable to a community psychology intervention, particularly in a South African context, where the aforementioned power imbalances continue to dominate.

This research therefore showed that it was not only the imminent closure that was traumatic but the failure of management at the CBO to empathically handle the situation. Instead, their approach re-evoked the trauma associated with historical power imbalances between black and white in South Africa. This showed that in the absence of new ways of relating, history is bound to be repeated. It is hoped that this research, by looking at the intersubjective intricacies in the relationships between community health workers and management, and community psychologists, has begun to shed some light on how community psychologists can develop new ways to work with community-based organisations that are susceptible to the trauma inherent in the community setting.

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## APPENDIX A: Staff support group sessions and themes

<i>Dates</i>	<i>Present</i>	<i>Themes</i>
<b>17 April</b>	Joyce, Nosenzo, Musa, Sandise and 3 facilitators. Absent: Shireen and Nomsa	<ul style="list-style-type: none"> <li>- Introduction and finding common ground between group and psychologists-in-training</li> <li>- Rumours about retrenchment</li> <li>- Splitting between good and bad: community health workers versus management</li> <li>- Anger, anxiety, distrust, paranoia</li> </ul>
<b>24 April</b>	Nosenzo, Nomsa, Joyce, Sandise and 3 facilitators	<ul style="list-style-type: none"> <li>- Ambivalence regarding group session and imminent closure</li> <li>- Split: exhaustion and passivity versus euphoria and manic mood</li> <li>- Betrayal and loss</li> <li>- Powerlessness and helplessness</li> <li>- Difficulty in recognising own value and self-worth</li> </ul>
<b>8 May</b>	Nomsa, Joyce, Sandise, Musa and 2 facilitators	<ul style="list-style-type: none"> <li>- Retrenchment was confirmed by management; health workers considering options for alternative employment</li> <li>- Group subdued and seemed in touch with reality of the imminent closure</li> <li>- Questioning of management of donor funding – distrusting management</li> <li>- Distress and denial of practical implications of retrenchment</li> <li>- FC<sup>22</sup>: Possible waste of skills when project closed down</li> </ul>
<b>23 May</b>	Sandise, Nosenzo, Nomsa, Shireen, Musa, Joyce, 3 facilitators and an outside researcher	<ul style="list-style-type: none"> <li>- All staff present, including project manager</li> <li>- Researcher gave positive feedback of her study on the project; group struggled to internalise this</li> <li>- Group struggling with being used for training and research</li> <li>- There was a need for safety, containment and protection from psychic pain</li> <li>- Denial and disbelief about imminent closure</li> </ul>
<b>19 June</b>	Joyce, Nomsa, Musa, Nosenzo, Sandise and 3 facilitators	<ul style="list-style-type: none"> <li>- Formal notice and ‘unfair’ retrenchment package, not reflecting their worth</li> <li>- Anger and feeling betrayed by management</li> <li>- Vulnerability and loss of identity and status as ‘care workers’</li> <li>- Members taking responsibility in terms of nurturance, consulting with workers’ union, looking for alternative employment</li> <li>- Ambivalence about their clients; concern, and frustration and anxiety about current work</li> <li>- Questioning the management of donor funding – distrusting management</li> <li>- FC: <i>Group need space to grieve and think outside</i></li> </ul>

<sup>22</sup> FC: Facilitators’ feelings and discussions after a staff group session, including counter-transference

		CBO
<b>University vacation</b>		
<b>17 July</b>	Sandise, Nosenzo, Joyce, Nomsa, Musa and 3 facilitators	<ul style="list-style-type: none"> <li>- Ambivalence about the recently mooted idea of having these sessions away from CBO even though group had made decision to do so; separation anxiety</li> <li>- Feeling abused and injured by CBO: “We need bandages and panados”; “We are kaffirs with short hair”</li> <li>- Fear of taking leadership role or ‘standing out’</li> <li>- Feeling split by management: some members will be not be retrenched</li> <li>- Need for validation of sense of self</li> <li>- Idealisation of permanent facilitator</li> <li>- Want to fight back and pursue legal action</li> <li>- FC: Need to rescue and save group</li> </ul>
<b>31 July</b>	Nomsa, Nosenzo, Sandise, Musa and 3 facilitators	<ul style="list-style-type: none"> <li>- Feeling abandoned by CBO</li> <li>- Anxious about abandoning the community</li> <li>- Ambivalence about accepting nurturance and care presented by the group sessions</li> <li>- Preoccupied with their internal state, and fatigued</li> <li>- Feeling isolated, lacking support from their families; anxious about their financial stability</li> <li>- Internalised trauma and structural oppression; situation at CBO mirrors their personal lives</li> <li>- Questioning the management of donor funding – distrusting management</li> </ul>
<b>14 August</b>	Musa, Nosenzo, Nomsa, Sandise, Joyce and 3 facilitators	<ul style="list-style-type: none"> <li>- Angry and rejecting facilitators, while at the same time fearing abandonment and perceiving them as source of nourishment</li> <li>- Fragile sense of self and worthiness; sensitive to affirmation and rejection</li> <li>- CBO not disbanding but becoming an NPO</li> <li>- Feeling uncared for and attacked by CBO and community: “There’s no truth in the world”</li> <li>- Spilling and splitting: “Its very difficult today, things are out of control”</li> <li>- Wanting to escape to Eastern Cape (home) – needing safety</li> </ul>
<b>28 August</b>	Joyce, Nosenzo, Sandise, Shireen, a visiting UK psychoanalyst and two facilitators (excluding the permanent facilitator)	<p>FC: The annual visit of the UK analyst aroused emotions for both the group and the psychologists-in-training. Her stated intention was to arouse the group into action.</p> <ul style="list-style-type: none"> <li>- Ambivalence about taking action. Fear of repercussions versus having nothing to lose because will retrenched anyway</li> <li>- Feelings of dependency and vulnerability evoked; group wanting to be rescued, visiting analyst’s gesture of giving them <i>money</i> reinforcing this, at the same time creating a sense of being appreciated and cared for.</li> </ul> <p>CBO was being closed because there was no money and the analyst raised the possibility of doing</p>

		<p>something to save the project.</p> <ul style="list-style-type: none"> <li>- Members overwhelmed: "It's too much"; they all wept</li> <li>- Clients have not been informed of the imminent closure</li> </ul>
<b>11 September</b>	Cancelled	<ul style="list-style-type: none"> <li>- Group members attending courses or sick: one of the community health workers informed us that we would not be having a session even though we were willing to have one</li> <li>- There is a rumour that permanent facilitator will not work with the group in 2003</li> </ul>
<b>25 September</b>	Sandise, Nosenzo and 1 facilitator (again not the permanent facilitator)	<p>Session again cancelled but one of the psychologists-in-training did not get the message. Sandise is willing to have session but Nosenzo has a client. Psychologist-in-training and members speak informally.</p> <ul style="list-style-type: none"> <li>- Group struggling to integrate after UK analyst's visit</li> <li>- A session arranged for 2 October</li> <li>- Members aware that psychologists-in-training would be leaving (end of year) which is linked to the closure of the organisation</li> <li>- FC: UK analyst's visit seems to have brought up unbearable feelings and cancelling the session is a form of coping with the pain.</li> </ul>
<b>2 October</b>	Joyce, Nosenzo, Sandise, 3 facilitators	<ul style="list-style-type: none"> <li>- First group session for 6 weeks and session is dominated by laughter</li> </ul> <p>The Board has suggested that management keep employing the community health workers until June 2003, they will have a salary cut, and will all be paid the same.</p> <ul style="list-style-type: none"> <li>- Renewed hope for funding and staying with CBO, health workers also grateful that this gives them time to find other employment</li> <li>- There is only one session left and this makes group surprised and anxious</li> <li>- Group members protective of this therapeutic space: "Why all these interruptions today?"</li> <li>- FC: sense of relief that group seems integrated after 6 weeks of fragmentation</li> </ul>
<b><i>Psychologists-in-trainings' end of year exams</i></b>		

<b>13 November</b>	Joyce, Nomsa, Nosenzo, Sandise, Musa, Shireen and 3 facilitators	<p>Annual end of the year party at CGC</p> <ul style="list-style-type: none"> <li>- Members tell their stories and experiences of apartheid government, of working 'illegally' without a pass<sup>23</sup> and getting arrested</li> <li>- Some group members mentioned that they still have an extra 'Coloured' surname: they took this to improve their chances of employment and rights in</li> </ul>
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<sup>23</sup> A document that black people were forced by law to carry with them all the time to prove that they had a 'right' to be in areas designated White, or face imprisonment.



		<p>the Western Cape; they also straighten their hair and try to change their accent</p> <ul style="list-style-type: none"> <li>- A sense of survival and triumph and also defeat, particularly with regards to CBO even though they have their jobs until June 2003</li> <li>- A lot of laughter and sadness in the group as they said goodbye to the psychologists-in-training (a ritual every year).</li> </ul>
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## **APPENDIX B: Letter to interviewees**

**To Whom It May Concern:**

**RE: Participating In the Research for M2 Thesis 2003**

I am a second year student in Clinical Psychology at UCT and currently conducting interviews for my master's thesis.

I am interested in [REDACTED] particularly the feelings and perceptions amongst staff about the challenges that the organisation was facing in 2002. These interviews will form part of my thesis towards my Masters degree in Clinical Psychology.

I will be grateful if we could meet for approximately an hour to discuss your experience at [REDACTED]. The interviews will be recorded but your identity will be kept confidential. Should you have any questions in this regard please do not hesitate to contact me on 084 3705653.

Yours Faithfully,

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Nontsikelelo Ndumela  
**Intern Clinical Psychologist**

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Sia Maw  
**Thesis Supervisor**

## APPENDIX C: Research proposal

### Title

To explore the Re-enactment of Embedded Trauma in a Human Service (Community-Based) Organisation in a Traumatized setting, who work with Children that are the victims of Trauma. Case Study: [REDACTED]<sup>24</sup> [REDACTED]

### Background

This thesis is based on a case study of the UCT Child Guidance Clinic (CGC) involvement with the [REDACTED]. The Project staff and CGC affiliation commenced six years ago when the initial Project Coordinator requested CGC to address staff training needs and to give support in dealing with stress and burnout.

The need to change the distribution of the skills in previously disadvantaged South African communities is well documented in community psychology literature (Donald, Dawes & Louw, 2000, Gibson, 2000 & 2002, Tomlinson & Swartz, 2002). The CGC developed a model of consultation to offer assistance and training to organisations that worked with children. The model was also established to offer students experience and exposure to community-based projects during their clinical psychology training (Gibson, 2000).

### Aim

This research will involve an exploration and reflection of the role of psychologists working within developmental projects. The aim is to explore the way in which work context impact on health community workers, their relation to each other as well as the organization as a whole. In particular, the effects of working with survivors of trauma and how this is in turn reflected in the organizational dynamics and culture.

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<sup>24</sup> Pseudonyms will be used in the thesis to protect the identity of the project and its staff.

Furthermore, this thesis will attempt to show ways in which the interaction of the external context, work content and the structure and management processes impacts on the staff. According to Gibson (2002) it is common for people who work with trauma victims to have similar strong emotional responses to those of their clients and these emotions are “commonly categorized as vicarious traumatization”. In her unpublished thesis Gibson further argues that the staff of the [REDACTED] “are not only dealing with their indirect experience of trauma through their clients, but live and work under conditions which are themselves traumatic” (2002, pg27). Using psychodynamic theory about the way organizations work (Obholzer & Robert, 1994, Gibson, 2000) it seems that organizations under stress tend to react in a similar way to individuals under stress. Gibson (2000, p227) argues that stress seems to overturn the organization’s own stated goals and interest as well as their ability to develop through the consultation 25process.

### **Method of data collection**

Literature Review will focus on development theory, Organisational Psychodynamic and Community Psychology Theories and will include a review of existing theories in explaining the dynamics in organizations such as [REDACTED]. Some of the literature to be discussed will include Fitzgerald, McLennan and Munslow (1999), Coetzee, Graaff, Hendriks & Wood (2001), Kaplan (1996), Orford (1992), Seedat, Duncan and Lazarus (2001), Obholzer & Robert, (1994), Gibson, (2000), Swartz (2000) and other relevant literature.

The data needed for this study:

1. Thoughts and perceptions of staff at the project site regarding their external and internal context and how it influences their work

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<sup>25</sup> The services provided by psychologists to organizations.

2. Thoughts and perceptions of Managements and Board members to the challenges posed by the external and internal context and how this influences their functioning
3. Organizational systems and their impact on each other, including nature of services provided and client group serviced

Method of collecting data will include; interviews with community health workers, management, selected board members, documents of the organization, therapeutic notes from the support group in 2002, my experience while working with the organization in 2002, during my first year of study. In addition, interviews with key stakeholders in the NGO sector (i.e CDRA and others) to contextualize the findings will be conducted.

### **WHY IS THIS STUDY VALUABLE?**

██████████ is based in ██████████ one of the most economically depressed communities in the Cape Flats. Plagued by poverty, ██████████ is faced with high level of unemployment, unchecked violent crime, and low levels of social services. According to the 2001 Government Census, ██████████ houses 329 009 people, living predominantly in informal housing. It is estimated that 53% of the employable population (age between 15 and 69 years) is unemployed, while 59% of the total population has a level of education that is below Grade 11 (Standard 8). A significant portion of people in ██████████ are single mothers with young children. Approximately one quarter of families did not have basic food security and 1997 crime statistics indicated that ██████████ was one of the most violent communities in Cape Town.

Since its inception, eleven years ago, the ██████████ community health workers have provided services to a significant number of people in ██████████ and surrounding areas. The

staff received referrals from several professional organisations and is also identified by these organisations as a valuable community resource and often the only recourse for some people.

Research such as this draws from a psychological perspective and hopes to provide data and interpretations of the data, which will contribute towards the ongoing work of [REDACTED]

To this end, the results of this research will be presented to the staff and management (including Board) of [REDACTED] in order for the organization to benefit, where possible, from this academic research.

## **THESIS OUTLINE (75 pages)**

1. Introductory chapter (5 pages)
2. Literature review (15-20 pages)
3. Methodology (5-10 pages)
4. Results analysis (15-30 pages)
5. Discussion/conclusion/recommendations (5 pages)

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Nontsikelelo Ndumela  
**Intern Clinical Psychologist**

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Sia Maw  
**Thesis Supervisor**

## **APPENDIX D: Interview guide**

### ***Semi-Structured Interview Questionnaire***

#### **Section A**

1. What was your role and responsibility in 2002 at [REDACTED]?
2. How do you know that you are doing well in your job?
3. How would you describe your clients? And which ones have you worked with most?
4. What is the most difficult thing about the work that you do?
5. How would you describe the way the organisation has been functioning in 2002? Has this has affected your work and How?
6. How does the organisation help to deal with difficulties in your work? If not. Who do you turn to for help?
7. What are the supervising and support structure in the organisation?
8. How does the organisation address conflict and disagreement?
9. How is the information shared in the organisation?

#### **Section B**

1. What was the vision of the organisation when it started 12 years ago?
2. What did the organisation aim to do?
3. Do you think the aim has change over time and What has changed? Why?
4. What made it possible for the organisation to achieve its aims?
5. What made it difficult for the organisation to its aims?
6. What were the long-term plans for the organisation, clients, and community?
7. Who are board members of the organisation?
8. Why does this organisation have a board and is the role and responsibility?
9. Who form part of management of the organisation?
10. What are the roles and responsibilities of the management team?

- 11. How often do you see the board and management team?
- 12. How would you describe the communication in the organisation?
- 13. How are you informed of the decisions made in the organisation?
- 14. How does your opinion influence those decisions?
- 15. How would you rate your enthusiasm (personal) about working in this organisation?

1	2	3	4	5	6	7	8	9	10
Extremely Low					Extremely High				

- 16. How would you rate enthusiasm amongst staff about working in this organisation?

1	2	3	4	5	6	7	8	9	10
Extremely Low					Extremely High				

- 17. Where do you see the organisation in the next 5 years? Why?
- 18. If you the head of the organisation what would change or do differently? Why?

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